

108TH CONGRESS  
1ST SESSION

# H. R. 3423

To amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for health insurance costs, to allow employees who elect not to participate in employer subsidized health plans an exclusion from gross income for employer payments in lieu of such participation, and for other purposes.

---

## IN THE HOUSE OF REPRESENTATIVES

OCTOBER 30, 2003

Mr. SHADEGG introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

## A BILL

To amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for health insurance costs, to allow employees who elect not to participate in employer subsidized health plans an exclusion from gross income for employer payments in lieu of such participation, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the  
3 “Patients’ Health Care Choice Act of 2003”.

4 (b) TABLE OF CONTENTS.—The table of contents of  
5 this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

Sec. 3. Purposes.

**TITLE I—HEALTHMARTS**

Sec. 101. Expansion of consumer choice through Healthmarts.

**TITLE II—HEALTH CARE ACCESS AND CHOICE THROUGH  
INDIVIDUAL MEMBERSHIP ASSOCIATIONS (IMAs)**

Sec. 201. Expansion of access and choice through individual membership associations (IMAs).

**TITLE III—FEDERAL MATCHING FUNDING FOR STATE  
INSURANCE EXPENDITURES**

Sec. 301. Federal matching funding for State insurance expenditures.

**TITLE IV—AFFORDABLE HEALTH COVERAGE FOR EMPLOYEES  
OF SMALL BUSINESSES**

Sec. 401. Short title of title.

Sec. 402. Rules.

Sec. 403. Clarification of treatment of single employer arrangements.

Sec. 404. Clarification of treatment of certain collectively bargained arrangements.

Sec. 405. Enforcement provisions.

Sec. 406. Cooperation between Federal and State authorities.

Sec. 407. Effective date and transitional and other rules.

**TITLE V—IMPROVEMENT TO ACCESS AND CHOICE OF HEALTH  
CARE**

Sec. 501. Refundable credit for health insurance costs.

Sec. 502. Exclusion for employer payments made to compensate employees who elect not to participate in employer-subsidized health plans.

Sec. 503. Expanded availability of medical savings accounts.

**TITLE VI—PATIENT ACCESS TO INFORMATION**

Sec. 601. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 602. Effective date.

1       (c) CONSTITUTIONAL AUTHORITY TO ENACT THIS  
2 LEGISLATION.—The constitutional authority upon which  
3 this Act rests is the power of Congress to regulate com-  
4 merce with foreign nations and among the several States,  
5 set forth in article I, section 8 of the United States Con-  
6 stitution.

7 **SEC. 2. FINDINGS.**

8       (a) NEED FOR STRUCTURAL REFORMS.—Congress  
9 finds that the majority of Americans are receiving health  
10 care of a quality unmatched elsewhere in the world but  
11 that the method by which health care currently is financed  
12 and delivered is inflationary and does not distribute qual-  
13 ity care to all Americans. Congress further finds that the  
14 major structural reforms must be implemented in order  
15 to institute a competitive system based on individual  
16 choice, under which each American is permitted individual  
17 choice to select the method of health care delivery which  
18 he believes is most appropriate for himself and his family,  
19 with appropriate assistance from the United States Gov-  
20 ernment. Such a system would introduce internal incen-  
21 tives for the cost-effective delivery of quality health care  
22 to the American people.

23       (b) SPECIFIC DEFICIENCIES.—Congress finds that  
24 the major deficiencies of the present method of delivering  
25 and financing health care as follows:

1           (1) EMPLOYER OWNERSHIP OF HEALTH BENE-  
2           FITS.—The biggest problem with health care today  
3           is that the tax code has encouraged employers, not  
4           individuals, to become the purchaser of health insur-  
5           ance. Employers have a tax incentive to offer health  
6           care benefits to their employees, which means that  
7           employers are truly the owner of the plan, not indi-  
8           viduals. Therefore employees, who are the consumers  
9           of health care services are unconcerned with and not  
10          involved with issues of cost and overutilize health  
11          care services in the belief that such services are  
12          “free”.

13          (2) INSUFFICIENT ACCESS.—Numerous persons  
14          are not able to obtain sufficient health care either  
15          because the necessary personnel and facilities are  
16          not located in their communities or because they do  
17          not have adequate financial resources to obtain such  
18          services, or both.

19          (3) EXCESSIVE GOVERNMENT REGULATION.—  
20          Continually increasing and complex Government reg-  
21          ulation of the economic aspects of the health care  
22          delivery system has proven ineffective in restraining  
23          costs and is itself expensive and counterproductive in  
24          fulfilling its purposes and detrimental to the care of  
25          patients.

1           (4) THIRD-PARTY PAYMENT SYSTEMS.—Pay-  
2       ment by third-party payers (including commercial in-  
3       surance companies and various levels of government)  
4       for the preponderance of the health care delivered  
5       each year insulates patients, as well as physicians,  
6       hospitals, and other deliverers of health care, from  
7       the need to consider the cost of treatment in addi-  
8       tion to the medical benefit expected from it.

9           (5) REASONABLE COST REIMBURSEMENT.—Re-  
10      imbursement of hospitals and other health care insti-  
11      tutions by third-party payers on the basis of reason-  
12      able costs of operation provides these institutions in-  
13      sufficient incentives to introduce more efficient  
14      methods of delivering care and at the same time di-  
15      minishes the extent to which these institutions and  
16      their patients are affected by the consequences of in-  
17      efficiency and overexpansion.

18          (6) GOVERNMENT AND THIRD-PARTY PAYER.—  
19      The present role of government as a third-party  
20      payer poses a conflict of interest whereby the Gov-  
21      ernment purchases or finances health care services  
22      and unilaterally determines the amount the deliverer  
23      will be paid for those services.

24          (7) LACK OF COMPETITION.—The present sys-  
25      tem of financing and regulation prevents health care

1 deliverers from competing with each other on the  
2 basis of efficiency and price as well as quality.

3 **SEC. 3. PURPOSES.**

4 The purposes of Act are—

5 (1) to make it possible for individuals, employ-  
6 ees, and the self-employed to purchase and own their  
7 own health insurance without suffering any negative  
8 tax consequences;

9 (2) to enable individuals to make their own in-  
10 formed choice of the method by which their health  
11 care is provided, the persons who deliver it, and the  
12 price they wish to pay for it;

13 (3) to assist individuals in obtaining and in  
14 paying for basic health care services;

15 (4) to render patients and deliverers sensitive to  
16 the cost of health care, giving them both the incen-  
17 tive and the ability to restrain undesired increases in  
18 health care costs;

19 (5) to simplify and rationalize the payment  
20 mechanism for health care services;

21 (6) to foster the development of numerous, var-  
22 ied, and innovative systems of providing health care  
23 which will compete against each other in terms of  
24 price, service, and quality, and thus allow the Amer-  
25 ican people to benefit from competitive forces which

will reward efficient and effective deliverers and eliminate those which provide unsatisfactory quality of care or are inefficient;

(7) to replace governmental regulation of the economic aspects of health care delivery with individual choice, private initiative, and marketplace incentives and disciplines;

(8) to encourage the development of systems of delivering health care which are capable of supplying a broad range of health care services in a comprehensive and systematic manner, and

(9) to preserve the independence of health care deliverers and encourage their close identification with and their accountability to the individuals they serve.

## **TITLE I—HEALTHMARTS**

### **SEC. 101. EXPANSION OF CONSUMER CHOICE THROUGH HEALTHMARTS.**

The Public Health Service Act is amended by adding at the end the following new title:

#### **“TITLE XXIX—HEALTHMARTS**

##### **“SEC. 2901. DEFINITION OF HEALTHMART.**

“(a) IN GENERAL.—For purposes of this title, the term ‘HealthMart’ means a legal entity that meets the following requirements:

1           “(1) ORGANIZATION.—The HealthMart is an  
2           organization operated under the direction of a board  
3           of directors which is composed of representatives of  
4           not fewer than 2 from each of the following:

5                   “(A) Employers.

6                   “(B) Employees.

7                   “(C) Individuals (other than those de-  
8                   scribed in subparagraph (B)) who are eligible to  
9                   participate in the HealthMart.

10                  “(D) Health care providers, which may be  
11                  physicians, other health care professionals,  
12                  health care facilities, or any combination there-  
13                  of.

14                  “(E) Entities, such as insurance compa-  
15                  nies, health maintenance organizations, and li-  
16                  censed provider-sponsored organizations, that  
17                  underwrite or administer health benefits cov-  
18                  erage.

19           “(2) OFFERING HEALTH BENEFITS COV-  
20           ERAGE.—

21                  “(A) DIFFERENT GROUPS.—The  
22                  HealthMart, in conjunction with those health  
23                  insurance issuers that offer health benefits cov-  
24                  erage through the HealthMart, makes available  
25                  health benefits coverage in the manner de-



scribed in subsection (b) to all employers, eligible employees, and individuals in the manner described in subsection (c)(2) at rates (including employer's and employee's share, if applicable) that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law. A HealthMart is deemed to be a group health plan for purposes of applying section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of this Act, and section 9802(b) of the Internal Revenue Code of 1986 (which limit variation among similarly situated individuals of required premiums for health benefits coverage on the basis of health status-related factors).

“(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

“(i) IN GENERAL.—Subject to clause (ii), the HealthMart may not offer health benefits coverage to an eligible employee or individual in a geographic area (as specified under paragraph (3)(A)) unless the same coverage is offered to all such employees or individuals in the same geo-

1 graphic area. Section 2711(a)(1)(B) of this  
2 Act limits denial of enrollment of certain  
3 eligible individuals under health benefits  
4 coverage in the small group market.

5 “(ii) CONSTRUCTION.—Nothing in  
6 this title shall be construed as requiring or  
7 permitting a health insurance issuer to  
8 provide coverage outside the service area of  
9 the issuer, as approved under State law.

10 “(C) NO FINANCIAL UNDERWRITING.—The  
11 HealthMart provides health benefits coverage  
12 only through contracts with health insurance  
13 issuers and does not assume insurance risk with  
14 respect to such coverage.

15 “(D) MINIMUM COVERAGE.—By the end of  
16 the first year of its operation and thereafter,  
17 the HealthMart maintains not fewer than 10  
18 purchasers and 100 members.

19 “(3) GEOGRAPHIC AREAS.—

20 “(A) SPECIFICATION OF GEOGRAPHIC  
21 AREAS.—The HealthMart shall specify the geo-  
22 graphic area (or areas) in which it makes avail-  
23 able health benefits coverage offered by health  
24 insurance issuers to employers, or individuals,  
25 as the case may be. Any such area shall encom-

1 pass at least one entire county or equivalent  
2 area.

3 “(B) MULTISTATE AREAS.—In the case of  
4 a HealthMart that serves more than one State,  
5 such geographic areas may be areas that in-  
6 clude portions of two or more contiguous  
7 States.

8 “(C) MULTIPLE HEALTHMARTS PER-  
9 MITTED IN SINGLE GEOGRAPHIC AREA.—Noth-  
10 ing in this title shall be construed as preventing  
11 the establishment and operation of more than  
12 one HealthMart in a geographic area or as lim-  
13 iting the number of HealthMarts that may op-  
14 erate in any area.

15 “(4) PROVISION OF ADMINISTRATIVE SERVICES  
16 TO PURCHASERS.—

17 “(A) IN GENERAL.—The HealthMart pro-  
18 vides administrative services for purchasers.  
19 Such services may include accounting, billing,  
20 enrollment information, and employee coverage  
21 status reports.

22 “(B) CONSTRUCTION.—Nothing in this  
23 subsection shall be construed as preventing a  
24 HealthMart from serving as an administrative  
25 service organization to any entity.

1           “(5) DISSEMINATION OF INFORMATION.—The  
2       HealthMart collects and disseminates (or arranges  
3       for the collection and dissemination of) consumer-  
4       oriented information on the scope, cost, and enrollee  
5       satisfaction of all coverage options offered through  
6       the HealthMart to its members and eligible individ-  
7       uals. Such information shall be defined by the  
8       HealthMart and shall be in a manner appropriate to  
9       the type of coverage offered. To the extent prac-  
10      ticable, such information shall include information  
11      on provider performance, locations and hours of op-  
12      eration of providers, outcomes, and similar matters.  
13      Nothing in this section shall be construed as pre-  
14      venting the dissemination of such information or  
15      other information by the HealthMart or by health  
16      insurance issuers through electronic or other means.

17           “(6) FILING INFORMATION.—The  
18      HealthMart—

19           “(A) files with the applicable Federal au-  
20      thority information that demonstrates the  
21      HealthMart’s compliance with the applicable re-  
22      quirements of this title; or

23           “(B) in accordance with rules established  
24      under section 2903(a), files with a State such

1 information as the State may require to dem-  
2 onstrate such compliance.

3 “(b) HEALTH BENEFITS COVERAGE REQUIRE-  
4 MENTS.—

5 “(1) COMPLIANCE WITH CONSUMER PROTEC-  
6 TION REQUIREMENTS.—Any health benefits coverage  
7 offered through a HealthMart shall—

8 “(A) be underwritten by a health insurance  
9 issuer that—

10 “(i) is licensed (or otherwise regu-  
11 lated) under State law,

12 “(ii) meets all applicable State stand-  
13 ards relating to consumer protection, sub-  
14 ject to section 2902(b), and

15 “(iii) offers the coverage under a con-  
16 tract with the HealthMart;

17 “(B) subject to paragraph (2), be approved  
18 or otherwise permitted to be offered under  
19 State law; and

20 “(C) provide full portability of creditable  
21 coverage for individuals who remain members of  
22 the same HealthMart notwithstanding that they  
23 change the employer through which they are  
24 members in accordance with the provisions of  
25 the parts 6 and 7 of subtitle B of title I of the

1 Employee Retirement Income Security Act of  
2 1974 and titles XXII and XXVII of this Act,  
3 so long as both employers are purchasers in the  
4 HealthMart, and notwithstanding that they terminate  
5 such employment, if the HealthMart  
6 permits enrollment directly by eligible individuals.  
7

8 “(2) ALTERNATIVE PROCESS FOR APPROVAL OF  
9 HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMINATION  
10 OR DELAY.—

11 “(A) IN GENERAL.—The requirement of  
12 paragraph (1)(B) shall not apply to a policy or  
13 product of health benefits coverage offered in a  
14 State if the health insurance issuer seeking to  
15 offer such policy or product files an application  
16 to waive such requirement with the applicable  
17 Federal authority, and the authority determines,  
18 based on the application and other evidence  
19 presented to the authority, that—

20 “(i) either (or both) of the grounds  
21 described in subparagraph (B) for approval  
22 of the application has been met; and

23 “(ii) the coverage meets the applicable  
24 State standards (other than those that  
25 have been preempted under section 2902).

1           “(B) GROUNDS.—The grounds described  
2           in this subparagraph with respect to a policy or  
3           product of health benefits coverage are as fol-  
4           lows:

5                   “(i) FAILURE TO ACT ON POLICY,  
6                   PRODUCT, OR RATE APPLICATION ON A  
7                   TIMELY BASIS.—The State has failed to  
8                   complete action on the policy or product  
9                   (or rates for the policy or product) within  
10                  90 days of the date of the State’s receipt  
11                  of a substantially complete application. No  
12                  period before the date of the enactment of  
13                  this section shall be included in deter-  
14                  mining such 90-day period.

15                  “(ii) DENIAL OF APPLICATION BASED  
16                  ON DISCRIMINATORY TREATMENT.—The  
17                  State has denied such an application  
18                  and—

19                   “(I) the standards or review  
20                   process imposed by the State as a  
21                   condition of approval of the policy or  
22                   product imposes either any material  
23                   requirements, procedures, or stand-  
24                   ards to such policy or product that  
25                   are not generally applicable to other

1 policies and products offered or any  
2 requirements that are preempted  
3 under section 2902; or

4 “(II) the State requires the  
5 issuer, as a condition of approval of  
6 the policy or product, to offer any pol-  
7 icy or product other than such policy  
8 or product.

9 “(C) ENFORCEMENT.—In the case of a  
10 waiver granted under subparagraph (A) to an  
11 issuer with respect to a State, the Secretary  
12 may enter into an agreement with the State  
13 under which the State agrees to provide for  
14 monitoring and enforcement activities with re-  
15 spect to compliance of such an issuer and its  
16 health insurance coverage with the applicable  
17 State standards described in subparagraph  
18 (A)(ii). Such monitoring and enforcement shall  
19 be conducted by the State in the same manner  
20 as the State enforces such standards with re-  
21 spect to other health insurance issuers and  
22 plans, without discrimination based on the type  
23 of issuer to which the standards apply. Such an  
24 agreement shall specify or establish mechanisms  
25 by which compliance activities are undertaken,



1 while not lengthening the time required to re-  
2 view and process applications for waivers under  
3 subparagraph (A).

4 “(3) EXAMPLES OF TYPES OF COVERAGE.—The  
5 benefits coverage made available through a  
6 HealthMart may include, but is not limited to, any  
7 of the following if it meets the other applicable re-  
8 quirements of this title:

9 “(A) Coverage through a health mainte-  
10 nance organization.

11 “(B) Coverage in connection with a pre-  
12 ferred provider organization.

13 “(C) Coverage in connection with a li-  
14 censed provider-sponsored organization.

15 “(D) Indemnity coverage through an insur-  
16 ance company.

17 “(E) Coverage offered in connection with a  
18 contribution into a medical savings account or  
19 flexible spending account.

20 “(F) Coverage that includes a point-of-  
21 service option.

22 “(G) Any combination of such types of  
23 coverage.

24 “(4) WELLNESS BONUSES FOR HEALTH PRO-  
25 MOTION.—Nothing in this title shall be construed as

1 precluding a health insurance issuer offering health  
2 benefits coverage through a HealthMart from estab-  
3 lishing premium discounts or rebates for members or  
4 from modifying otherwise applicable copayments or  
5 deductibles in return for adherence to programs of  
6 health promotion and disease prevention so long as  
7 such programs are agreed to in advance by the  
8 HealthMart and comply with all other provisions of  
9 this title and do not discriminate among similarly  
10 situated members.

11 “(c) PURCHASERS; MEMBERS; HEALTH INSURANCE  
12 ISSUERS.—

13 “(1) PURCHASERS.—

14 “(A) IN GENERAL.—Subject to the provi-  
15 sions of this title, a HealthMart shall permit  
16 any employer or any individual described in  
17 subsection (a)(1)(C) to contract with the  
18 HealthMart for the purchase of health benefits  
19 coverage for its employees and dependents of  
20 those employees or for the individual (and the  
21 individual’s dependents), respectively, and may  
22 not vary conditions of eligibility (including pre-  
23 mium rates and membership fees) of an em-  
24 ployer or individual to be a purchaser.

1           “(B) ROLE OF ASSOCIATIONS, BROKERS,  
2           AND LICENSED HEALTH INSURANCE AGENTS.—

3           Nothing in this section shall be construed as  
4           preventing an association, broker, licensed  
5           health insurance agent, or other entity from as-  
6           sisting or representing a HealthMart or employ-  
7           ers or individuals from entering into appro-  
8           priate arrangements to carry out this title.

9           “(C) PERIOD OF CONTRACT.—The  
10          HealthMart may not require a contract under  
11          subparagraph (A) between a HealthMart and a  
12          purchaser to be effective for a period of longer  
13          than 24 months. The previous sentence shall  
14          not be construed as preventing such a contract  
15          from being extended for additional 24-month  
16          periods or preventing the purchaser from volun-  
17          tarily electing a contract period of longer than  
18          24 months.

19          “(D) EXCLUSIVE NATURE OF CON-  
20          TRACT.—

21                 “(i) IN GENERAL.—Subject to clause  
22                 (ii), such a contract shall provide that the  
23                 purchaser agrees not to obtain or sponsor  
24                 health benefits coverage, on behalf of any

1 eligible employees (and their dependents),  
2 other than through the HealthMart.

3 “(ii) EXCEPTION IF NO COVERAGE OF-  
4 FERRED IN AREA OF RESIDENCES.—Clause  
5 (i) shall not apply to an eligible individual  
6 who resides in an area for which no cov-  
7 erage is offered by any health insurance  
8 issuer through the HealthMart.

9 “(iii) NOTHING PRECLUDING INDI-  
10 VIDUAL EMPLOYEE OPT-OUT.—Nothing in  
11 this subparagraph shall be construed as re-  
12 quiring an eligible employee of a large or  
13 small employer that is a purchaser to ob-  
14 tain health benefits coverage through the  
15 HealthMart.

16 “(2) MEMBERS.—

17 “(A) IN GENERAL.—

18 “(i) EMPLOYMENT BASED MEMBER-  
19 SHIP.—Under rules established to carry  
20 out this title, with respect to an employer  
21 that has a purchaser contract with a  
22 HealthMart, individuals who are employees  
23 of the employer may enroll for health bene-  
24 fits coverage (including coverage for de-  
25 pendants of such enrolling employees) of-

1           ferred by a health insurance issuer through  
2           the HealthMart.

3           “(ii) INDIVIDUALS.—Under rules es-  
4           tablished to carry out this title, with re-  
5           spect to an individual who has a purchaser  
6           contract with a HealthMart for himself or  
7           herself, the individual may enroll for health  
8           benefits coverage (including coverage for  
9           dependents of such individual) offered by a  
10          health insurance issuer through the  
11          HealthMart.

12          “(B) NONDISCRIMINATION IN ENROLL-  
13          MENT.—A HealthMart may not deny enroll-  
14          ment as a member to an individual who is an  
15          employee or individual (or dependent of such an  
16          employee or individual) eligible to be so enrolled  
17          based on health status-related factors, except as  
18          may be permitted consistent with section  
19          2742(b).

20          “(C) ANNUAL OPEN ENROLLMENT PE-  
21          RIOD.—In the case of members enrolled in  
22          health benefits coverage offered by a health in-  
23          surance issuer through a HealthMart, subject  
24          to subparagraph (D), the HealthMart shall pro-  
25          vide for an annual open enrollment period of 30

1 days during which such members may change  
2 the coverage option in which the members are  
3 enrolled.

4 “(D) RULES OF ELIGIBILITY.—Nothing in  
5 this paragraph shall preclude a HealthMart  
6 from establishing rules of employee or indi-  
7 vidual eligibility for enrollment and reenroll-  
8 ment of members during the annual open en-  
9 rollment period under subparagraph (C). Such  
10 rules shall be applied consistently to all pur-  
11 chasers and members within the HealthMart  
12 and shall not be based in any manner on health  
13 status-related factors and may not conflict with  
14 sections 2701 and 2702 of this Act.

15 “(3) HEALTH INSURANCE ISSUERS.—

16 “(A) PREMIUM COLLECTION.—The con-  
17 tract between a HealthMart and a health insur-  
18 ance issuer shall provide, with respect to a  
19 member enrolled with health benefits coverage  
20 offered by the issuer through the HealthMart,  
21 for the payment of the premiums collected by  
22 the HealthMart (or the issuer) for such cov-  
23 erage (less a pre-determined administrative  
24 charge negotiated by the HealthMart and the  
25 issuer) to the issuer.

1           “(B) SCOPE OF SERVICE AREA.—Nothing  
2           in this title shall be construed as requiring the  
3           service area of a health insurance issuer with  
4           respect to health insurance coverage to cover  
5           the entire geographic area served by a  
6           HealthMart.

7           “(C) AVAILABILITY OF COVERAGE OP-  
8           TIONS.—

9           “(i) IN GENERAL.—A HealthMart  
10          shall enter into contracts with one or more  
11          health insurance issuers in a manner that  
12          assures that at least 2 health insurance  
13          coverage options are made available.

14          “(ii) REQUIREMENT OF NON-NET-  
15          WORK OPTION.—At least one of the health  
16          insurance coverage options made available  
17          under clause (i) shall be a non-network  
18          coverage option under which enrollees may  
19          obtain benefits for health care items and  
20          services that are not provided under a con-  
21          tract between the provider of the service  
22          and the issuer involved.

23          “(d) PREVENTION OF CONFLICTS OF INTEREST.—

24          “(1) FOR BOARDS OF DIRECTORS.—A member  
25          of a board of directors of a HealthMart may not

1 serve as an employee or paid consultant to the  
2 HealthMart, but may receive reasonable reimburse-  
3 ment for travel expenses for purposes of attending  
4 meetings of the board or committees thereof.

5 “(2) FOR BOARDS OF DIRECTORS OR EMPLOY-  
6 EES.—An individual is not eligible to serve in a paid  
7 or unpaid capacity on the board of directors of a  
8 HealthMart or as an employee of the HealthMart, if  
9 the individual is employed by, represents in any ca-  
10 pacity, owns, or controls any ownership interest in  
11 an organization from whom the HealthMart receives  
12 contributions, grants, or other funds not connected  
13 with a contract for coverage through the  
14 HealthMart.

15 “(3) EMPLOYMENT AND EMPLOYEE REP-  
16 RESENTATIVES.—

17 “(A) IN GENERAL.—An individual who is  
18 serving on a board of directors of a HealthMart  
19 as a representative described in subparagraph  
20 (A) or (B) of section 2901(a)(1) shall not be  
21 employed by or affiliated with a health insur-  
22 ance issuer or be licensed as or employed by or  
23 affiliated with a health care provider.

24 “(B) CONSTRUCTION.—For purposes of  
25 subparagraph (A), the term “affiliated” does



1 not include membership in a health benefits  
2 plan or the obtaining of health benefits cov-  
3 erage offered by a health insurance issuer.

4 “(e) CONSTRUCTION.—

5 “(1) NETWORK OF AFFILIATED  
6 HEALTHMARTS.—Nothing in this section shall be  
7 construed as preventing one or more HealthMarts  
8 serving different areas (whether or not contiguous)  
9 from providing for some or all of the following  
10 (through a single administrative organization or oth-  
11 erwise):

12 “(A) Coordinating the offering of the same  
13 or similar health benefits coverage in different  
14 areas served by the different HealthMarts.

15 “(B) Providing for crediting of deductibles  
16 and other cost-sharing for individuals who are  
17 provided health benefits coverage through the  
18 HealthMarts (or affiliated HealthMarts)  
19 after—

20 “(i) a change of employers through  
21 which the coverage is provided, or

22 “(ii) a change in place of employment  
23 to an area not served by the previous  
24 HealthMart.

1           “(2) PERMITTING HEALTHMARTS TO ADJUST  
2       DISTRIBUTIONS AMONG ISSUERS TO REFLECT REL-  
3       ATIVE RISK OF ENROLLEES.—Nothing in this sec-  
4       tion shall be construed as precluding a HealthMart  
5       from providing for adjustments in amounts distrib-  
6       uted among the health insurance issuers offering  
7       health benefits coverage through the HealthMart  
8       based on factors such as the relative health care risk  
9       of members enrolled under the coverage offered by  
10      the different issuers.

11   **“SEC. 2902. APPLICATION OF CERTAIN LAWS AND REQUIRE-**  
12                           **MENTS.**

13           “(a) AUTHORITY OF STATES.—Nothing in this sec-  
14      tion shall be construed as preempting State laws relating  
15      to the following:

16           “(1) The regulation of underwriters of health  
17      coverage, including licensure and solvency require-  
18      ments.

19           “(2) The application of premium taxes and re-  
20      quired payments for guaranty funds or for contribu-  
21      tions to high-risk pools.

22           “(3) The application of fair marketing require-  
23      ments and other consumer protections (other than  
24      those specifically relating to an item described in  
25      subsection (b)).

1           “(4) The application of requirements relating to  
2           the adjustment of rates for health insurance cov-  
3           erage.

4           “(b) TREATMENT OF BENEFIT AND GROUPING RE-  
5           QUIREMENTS.—State laws insofar as they relate to any  
6           of the following are superseded and shall not apply to  
7           health benefits coverage made available through a  
8           HealthMart:

9           “(1) Benefit requirements for health benefits  
10          coverage offered through a HealthMart, including  
11          (but not limited to) requirements relating to cov-  
12          erage of specific providers, specific services or condi-  
13          tions, or the amount, duration, or scope of benefits,  
14          but not including requirements to the extent re-  
15          quired to implement title XXVII or other Federal  
16          law and to the extent the requirement prohibits an  
17          exclusion of a specific disease from such coverage.

18          “(2) Requirements (commonly referred to as  
19          fictitious group laws) relating to grouping and simi-  
20          lar requirements for such coverage to the extent  
21          such requirements impede the establishment and op-  
22          eration of HealthMarts pursuant to this title.

23          “(3) Any other requirements (including limita-  
24          tions on compensation arrangements) that, directly  
25          or indirectly, preclude (or have the effect of pre-

1 including) the offering of such coverage through a  
2 HealthMart, if the HealthMart meets the require-  
3 ments of this title.

4 Any State law or regulation relating to the composition  
5 or organization of a HealthMart is preempted to the ex-  
6 tent the law or regulation is inconsistent with the provi-  
7 sions of this title.

8 “(c) APPLICATION OF ERISA FIDUCIARY AND DIS-  
9 CLOSURE REQUIREMENTS.—The board of directors of a  
10 HealthMart is deemed to be a plan administrator of an  
11 employee welfare benefit plan which is a group health plan  
12 for purposes of applying parts 1 and 4 of subtitle B of  
13 title I of the Employee Retirement Income Security Act  
14 of 1974 and those provisions of part 5 of such subtitle  
15 which are applicable to enforcement of such parts 1 and  
16 4, and the HealthMart shall be treated as such a plan  
17 and the enrollees enrolled on the basis of employment shall  
18 be treated as participants and beneficiaries for purposes  
19 of applying such provisions pursuant to this subsection.

20 “(d) APPLICATION OF ERISA RENEWABILITY PRO-  
21 TECTION.—A HealthMart is deemed to be group health  
22 plan that is a multiple employer welfare arrangement for  
23 purposes of applying section 703 of the Employee Retire-  
24 ment Income Security Act of 1974.

1       “(e) APPLICATION OF RULES FOR NETWORK PLANS  
2 AND FINANCIAL CAPACITY.—The provisions of sub-  
3 sections (c) and (d) of section 2711 apply to health bene-  
4 fits coverage offered by a health insurance issuer through  
5 a HealthMart.

6       “(f) CONSTRUCTION RELATING TO OFFERING RE-  
7 QUIREMENT.—Nothing in section 2711(a) of this Act or  
8 703 of the Employee Retirement Income Security Act of  
9 1974 shall be construed as permitting the offering outside  
10 the HealthMart of health benefits coverage that is only  
11 made available through a HealthMart under this section  
12 because of the application of subsection (b).

13       “(g) APPLICATION TO GUARANTEED RENEWABILITY  
14 REQUIREMENTS IN CASE OF DISCONTINUATION OF AN  
15 ISSUER.—For purposes of applying section 2712 in the  
16 case of health insurance coverage offered by a health in-  
17 surance issuer through a HealthMart, if the contract be-  
18 tween the HealthMart and the issuer is terminated and  
19 the HealthMart continues to make available any health in-  
20 surance coverage after the date of such termination, the  
21 following rules apply:

22               “(1) RENEWABILITY.—The HealthMart shall  
23 fulfill the obligation under such section of the issuer  
24 renewing and continuing in force coverage by offer-  
25 ing purchasers (and members and their dependents)

1 all available health benefits coverage that would oth-  
2 erwise be available to similarly-situated purchasers  
3 and members from the remaining participating  
4 health insurance issuers in the same manner as  
5 would be required of issuers under section 2712(c).

6 “(2) APPLICATION OF ASSOCIATION RULES.—  
7 The HealthMart shall be considered an association  
8 for purposes of applying section 2712(e).

9 “(h) CONSTRUCTION IN RELATION TO CERTAIN  
10 OTHER LAWS.—Nothing in this title shall be construed  
11 as modifying or affecting the applicability to HealthMarts  
12 or health benefits coverage offered by a health insurance  
13 issuer through a HealthMart of parts 6 and 7 of subtitle  
14 B of title I of the Employee Retirement Income Security  
15 Act of 1974 or titles XXII and XXVII of this Act.

16 **“SEC. 2903. ADMINISTRATION.**

17 “(a) IN GENERAL.—The applicable Federal authority  
18 shall administer this title and is authorized to issue such  
19 regulations as may be required to carry out this title. Such  
20 regulations shall be subject to Congressional review under  
21 the provisions of chapter 8 of title 5, United States Code.  
22 The applicable Federal authority shall incorporate the  
23 process of ‘deemed file and use’ with respect to the infor-  
24 mation filed under section 2901(a)(6)(A) and shall deter-  
25 mine whether information filed by a HealthMart dem-

1 onstrates compliance with the applicable requirements of  
 2 this title. Such authority shall exercise its authority under  
 3 this title in a manner that fosters and promotes the devel-  
 4 opment of HealthMarts in order to improve access to  
 5 health care coverage and services.

6 “(b) PERIODIC REPORTS.—The applicable Federal  
 7 authority shall submit to Congress a report every 30  
 8 months, during the 10-year period beginning on the effec-  
 9 tive date of the rules promulgated by the applicable Fed-  
 10 eral authority to carry out this title, on the effectiveness  
 11 of this title in promoting coverage of uninsured individ-  
 12 uals. Such authority may provide for the production of  
 13 such reports through one or more contracts with appro-  
 14 priate private entities.

15 **“SEC. 2904. DEFINITIONS.**

16 “For purposes of this title:

17 “(1) APPLICABLE FEDERAL AUTHORITY.—The  
 18 term ‘applicable Federal authority’ means the Sec-  
 19 retary of Health and Human Services .

20 “(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—  
 21 The term ‘eligible’ means, with respect to an em-  
 22 ployee or other individual and a HealthMart, an em-  
 23 ployee or individual who is eligible under section  
 24 2901(c)(2) to enroll or be enrolled in health benefits  
 25 coverage offered through the HealthMart.

1           “(3) EMPLOYER; EMPLOYEE; DEPENDENT.—  
2       Except as the applicable Federal authority may oth-  
3       erwise provide, the terms ‘employer’, ‘employee’, and  
4       ‘dependent’, as applied to health insurance coverage  
5       offered by a health insurance issuer licensed (or oth-  
6       erwise regulated) in a State, shall have the meanings  
7       applied to such terms with respect to such coverage  
8       under the laws of the State relating to such coverage  
9       and such an issuer. The term ‘dependent’ may in-  
10      clude the spouse and children of the individual in-  
11      volved.

12           “(4) HEALTH BENEFITS COVERAGE.—The term  
13      ‘health benefits coverage’ has the meaning given the  
14      term group health insurance coverage in section  
15      2791(b)(4).

16           “(5) HEALTH INSURANCE ISSUER.—The term  
17      ‘health insurance issuer’ has the meaning given such  
18      term in section 2791(b)(2).

19           “(6) HEALTH STATUS-RELATED FACTOR.—The  
20      term ‘health status-related factor’ has the meaning  
21      given such term in section 2791(d)(9).

22           “(7) HEALTHMART.—The term ‘HealthMart’ is  
23      defined in section 2901(a).

24           “(8) MEMBER.—The term ‘member’ means,  
25      with respect to a HealthMart, an individual enrolled



1 for health benefits coverage through the HealthMart  
2 under section 2901(c)(2).

3 “(9) PURCHASER.—The term ‘purchaser’  
4 means, with respect to a HealthMart, an employer  
5 or individual that has contracted under section  
6 2901(c)(1)(A) with the HealthMart for the purchase  
7 of health benefits coverage.”.

8 **TITLE II—HEALTH CARE ACCESS**  
9 **AND CHOICE THROUGH INDIVIDUAL**  
10 **MEMBERSHIP ASSOCIATIONS (IMAs)**  
11

12 **SEC. 201. EXPANSION OF ACCESS AND CHOICE THROUGH**  
13 **INDIVIDUAL MEMBERSHIP ASSOCIATIONS**  
14 **(IMAs).**

15 The Public Health Service Act, as amended by sec-  
16 tion 101, is further amended by adding at the end the  
17 following new title:

18 “TITLE XXX—INDIVIDUAL MEMBERSHIP  
19 ASSOCIATIONS

20 **“SEC. 3001. DEFINITION OF INDIVIDUAL MEMBERSHIP AS-**  
21 **SOCIATION (IMA).**

22 “(a) IN GENERAL.—For purposes of this title, the  
23 terms ‘individual membership association’ and ‘IMA’  
24 mean a legal entity that meets the following requirements:

1           “(1) ORGANIZATION.—The IMA is an organiza-  
2           tion operated under the direction of an association  
3           (as defined in section 3004(1)).

4           “(2) OFFERING HEALTH BENEFITS COV-  
5           ERAGE.—

6           “(A) DIFFERENT GROUPS.—The IMA, in  
7           conjunction with those health insurance issuers  
8           that offer health benefits coverage through the  
9           IMA, makes available health benefits coverage  
10          in the manner described in subsection (b) to all  
11          members of the IMA and the dependents of  
12          such members in the manner described in sub-  
13          section (c)(2) at rates that are established by  
14          the health insurance issuer on a policy or prod-  
15          uct specific basis and that may vary only as  
16          permissible under State law.

17          “(B) NONDISCRIMINATION IN COVERAGE  
18          OFFERED.—

19                 “(i) IN GENERAL.—Subject to clause  
20                 (ii), the IMA may not offer health benefits  
21                 coverage to a member of an IMA unless  
22                 the same coverage is offered to all such  
23                 members of the IMA.

24                 “(ii) CONSTRUCTION.—Nothing in  
25                 this title shall be construed as requiring or

1           permitting a health insurance issuer to  
2           provide coverage outside the service area of  
3           the issuer, as approved under State law, or  
4           requiring a health insurance issuer from  
5           excluding or limiting the coverage on any  
6           individual, subject to the requirement of  
7           section 2741.

8           “(C) NO FINANCIAL UNDERWRITING.—The  
9           IMA provides health benefits coverage only  
10          through contracts with health insurance issuers  
11          and does not assume insurance risk with re-  
12          spect to such coverage.

13          “(3) GEOGRAPHIC AREAS.—Nothing in this title  
14          shall be construed as preventing the establishment  
15          and operation of more than one IMA in a geographic  
16          area or as limiting the number of IMAs that may  
17          operate in any area.

18          “(4) PROVISION OF ADMINISTRATIVE SERVICES  
19          TO PURCHASERS.—

20                 “(A) IN GENERAL.—The IMA may provide  
21                 administrative services for members. Such serv-  
22                 ices may include accounting, billing, and enroll-  
23                 ment information.

24                 “(B) CONSTRUCTION.—Nothing in this  
25                 subsection shall be construed as preventing an

1 IMA from serving as an administrative service  
2 organization to any entity.

3 “(5) FILING INFORMATION.—The IMA files  
4 with the Secretary information that demonstrates  
5 the IMA’s compliance with the applicable require-  
6 ments of this title.

7 “(b) HEALTH BENEFITS COVERAGE REQUIRE-  
8 MENTS.—

9 “(1) COMPLIANCE WITH CONSUMER PROTEC-  
10 TION REQUIREMENTS.—Any health benefits coverage  
11 offered through an IMA shall—

12 “(A) be underwritten by a health insurance  
13 issuer that—

14 “(i) is licensed (or otherwise regu-  
15 lated) under State law,

16 “(ii) meets all applicable State stand-  
17 ards relating to consumer protection, sub-  
18 ject to section 3002(b), and

19 “(B) subject to paragraph (2), be approved  
20 or otherwise permitted to be offered under  
21 State law.

22 “(2) EXAMPLES OF TYPES OF COVERAGE.—The  
23 benefits coverage made available through an IMA  
24 may include, but is not limited to, any of the fol-

1       lowing if it meets the other applicable requirements  
2       of this title:

3               “(A) Coverage through a health mainte-  
4               nance organization.

5               “(B) Coverage in connection with a pre-  
6               ferred provider organization.

7               “(C) Coverage in connection with a li-  
8               censed provider-sponsored organization.

9               “(D) Indemnity coverage through an insur-  
10              ance company.

11              “(E) Coverage offered in connection with a  
12              contribution into a medical savings account or  
13              flexible spending account.

14              “(F) Coverage that includes a point-of-  
15              service option.

16              “(G) Any combination of such types of  
17              coverage.

18              “(3) WELLNESS BONUSES FOR HEALTH PRO-  
19              MOTION.—Nothing in this title shall be construed as  
20              precluding a health insurance issuer offering health  
21              benefits coverage through an IMA from establishing  
22              premium discounts or rebates for members or from  
23              modifying otherwise applicable copayments or  
24              deductibles in return for adherence to programs of  
25              health promotion and disease prevention so long as

1       such programs are agreed to in advance by the IMA  
2       and comply with all other provisions of this title and  
3       do not discriminate among similarly situated mem-  
4       bers.

5       “(c) MEMBERS; HEALTH INSURANCE ISSUERS.—

6               “(1) MEMBERS.—

7                       “(A) IN GENERAL.—Under rules estab-  
8                       lished to carry out this title, with respect to an  
9                       individual who is a member of an IMA, the in-  
10                      dividual may enroll for health benefits coverage  
11                      (including coverage for dependents of such indi-  
12                      vidual) offered by a health insurance issuer  
13                      through the IMA.

14                     “(B) RULES FOR ENROLLMENT.—Nothing  
15                     in this paragraph shall preclude an IMA from  
16                     establishing rules of enrollment and reenroll-  
17                     ment of members. Such rules shall be applied  
18                     consistently to all members within the IMA and  
19                     shall not be based in any manner on health sta-  
20                     tus-related factors.

21                     “(2) HEALTH INSURANCE ISSUERS.—The con-  
22                     tract between an IMA and a health insurance issuer  
23                     shall provide, with respect to a member enrolled with  
24                     health benefits coverage offered by the issuer

1 through the IMA, for the payment of the premiums  
2 collected by the issuer.

3 **“SEC. 3002. APPLICATION OF CERTAIN LAWS AND REQUIRE-**  
4 **MENTS.**

5 “State laws insofar as they relate to any of the fol-  
6 lowing are superseded and shall not apply to health bene-  
7 fits coverage made available through an IMA:

8 “(1) Benefit requirements for health benefits  
9 coverage offered through an IMA, including (but not  
10 limited to) requirements relating to coverage of spe-  
11 cific providers, specific services or conditions, or the  
12 amount, duration, or scope of benefits, but not in-  
13 cluding requirements to the extent required to imple-  
14 ment title XXVII or other Federal law and to the  
15 extent the requirement prohibits an exclusion of a  
16 specific disease from such coverage.

17 “(2) Any other requirements (including limita-  
18 tions on compensation arrangements) that, directly  
19 or indirectly, preclude (or have the effect of pre-  
20 cluding) the offering of such coverage through an  
21 IMA, if the IMA meets the requirements of this  
22 title.

23 Any State law or regulation relating to the composition  
24 or organization of an IMA is preempted to the extent the

1 law or regulation is inconsistent with the provisions of this  
2 title.

3 **“SEC. 3003. ADMINISTRATION.**

4       “(a) IN GENERAL.—The Secretary shall administer  
5 this title and is authorized to issue such regulations as  
6 may be required to carry out this title. Such regulations  
7 shall be subject to Congressional review under the provi-  
8 sions of chapter 8 of title 5, United States Code. The Sec-  
9 retary shall incorporate the process of ‘deemed file and  
10 use’ with respect to the information filed under section  
11 3001(a)(5)(A) and shall determine whether information  
12 filed by an IMA demonstrates compliance with the applica-  
13 ble requirements of this title. The Secretary shall exercise  
14 authority under this title in a manner that fosters and  
15 promotes the development of IMAs in order to improve  
16 access to health care coverage and services.

17       “(b) PERIODIC REPORTS.—The Secretary shall sub-  
18 mit to Congress a report every 30 months, during the 10-  
19 year period beginning on the effective date of the rules  
20 promulgated by the Secretary to carry out this title, on  
21 the effectiveness of this title in promoting coverage of un-  
22 insured individuals. The Secretary may provide for the  
23 production of such reports through one or more contracts  
24 with appropriate private entities.



1 **“SEC. 3004. DEFINITIONS.**

2 “For purposes of this title:

3 “(1) ASSOCIATION.—The term ‘association’  
4 means, with respect to health insurance coverage of-  
5 fered in a State, an association which—

6 “(A) has been actively in existence for at  
7 least 5 years;

8 “(B) has been formed and maintained in  
9 good faith for purposes other than obtaining in-  
10 surance;

11 “(C) does not condition membership in the  
12 association on any health status-related factor  
13 relating to an individual (including an employee  
14 of an employer or a dependent of an employee);  
15 and

16 “(D) does not make health insurance cov-  
17 erage offered through the association available  
18 other than in connection with a member of the  
19 association.

20 “(2) DEPENDENT.—The term ‘dependent’, as  
21 applied to health insurance coverage offered by a  
22 health insurance issuer licensed (or otherwise regu-  
23 lated) in a State, shall have the meaning applied to  
24 such term with respect to such coverage under the  
25 laws of the State relating to such coverage and such

1 an issuer. Such term may include the spouse and  
2 children of the individual involved.

3 “(3) HEALTH BENEFITS COVERAGE.—The term  
4 ‘health benefits coverage’ has the meaning given the  
5 term health insurance coverage in section  
6 2791(b)(1).

7 “(4) HEALTH INSURANCE ISSUER.—The term  
8 ‘health insurance issuer’ has the meaning given such  
9 term in section 2791(b)(2).

10 “(5) HEALTH STATUS-RELATED FACTOR.—The  
11 term ‘health status-related factor’ has the meaning  
12 given such term in section 2791(d)(9).

13 “(6) IMA; INDIVIDUAL MEMBERSHIP ASSOCIA-  
14 TION.—The terms ‘IMA’ and ‘individual membership  
15 association’ are defined in section 3001(a).

16 “(7) MEMBER.—The term ‘member’ means,  
17 with respect to an IMA, an individual who is a mem-  
18 ber of the association to which the IMA is offering  
19 coverage.”.

1 **TITLE III—FEDERAL MATCHING**  
2 **FUNDING FOR STATE INSUR-**  
3 **ANCE EXPENDITURES**

4 **SEC. 301. FEDERAL MATCHING FUNDING FOR STATE IN-**  
5 **SURANCE EXPENDITURES.**

6 (a) IN GENERAL.—Subject to the succeeding provi-  
7 sions of this section, each State shall receive from the Sec-  
8 retary of Health and Human Services an amount equal  
9 to 50 percent of the funds expended by the State in pro-  
10 viding for the use, in connection with providing health ben-  
11 efits coverage, of a high-risk pool, a reinsurance pool, or  
12 other risk-adjustment mechanism used for the purpose of  
13 subsidizing the purchase of private health insurance.

14 (b) FUNDING LIMITATION.—A State shall not receive  
15 under this section for a fiscal year more than a total of  
16 50 cents multiplied by the average number of residents  
17 (as estimated by the Secretary) in the State in the fiscal  
18 year.

19 (c) ADMINISTRATION.—The Secretary of Health and  
20 Human Services shall provide for the administration of  
21 this section and may establish such terms and conditions,  
22 including the requirement of an application, as may be ap-  
23 propriate to carry out this section.

24 (d) CONSTRUCTION.—Nothing in this section shall be  
25 construed as requiring a State to operate a reinsurance

1 pool (or other risk-adjustment mechanism) under this sec-  
 2 tion or as preventing a State from operating such a pool  
 3 or mechanism through one or more private entities.

4 (e) HIGH-RISK POOL.—For purposes of this section,  
 5 the term “high-risk pool” means any qualified high risk  
 6 pool (as defined in section 2744(c)(2) of the Public Health  
 7 Service Act).

8 (f) REINSURANCE POOL OR OTHER RISK-ADJUST-  
 9 MENT MECHANISM DEFINED.—For purposes of this sec-  
 10 tion, the term “reinsurance pool or other risk-adjustment  
 11 mechanism” means any State-based risk spreading mecha-  
 12 nism to subsidize the purchase of private health insurance  
 13 for the high-risk population.

14 (g) HIGH-RISK POPULATION.—For purposes of this  
 15 section, the term “high-risk population” means—

16 (1) individuals who, by reason of the existence  
 17 or history of a medical condition, are able to acquire  
 18 health coverage only at rates which are at least 150  
 19 percent of the standard risk rates for such coverage,  
 20 and

21 (2) individuals who are provided health cov-  
 22 erage by a high-risk pool.

23 (h) STATE DEFINED.—For purposes of this section,  
 24 the term “State” includes the District of Columbia, Puer-

1 to Rico, the Virgin Islands, Guam, American Samoa, and  
 2 the Northern Mariana Islands.

3 **TITLE IV—AFFORDABLE HEALTH**  
 4 **COVERAGE FOR EMPLOYEES**  
 5 **OF SMALL BUSINESSES**

6 **SEC. 401. SHORT TITLE OF TITLE.**

7 This title may be cited as the “Small Business Access  
 8 and Choice for Entrepreneurs Act of 2003”.

9 **SEC. 402. RULES.**

10 (a) IN GENERAL.—Subtitle B of title I of the Em-  
 11 ployee Retirement Income Security Act of 1974 is amend-  
 12 ed by adding after part 7 the following new part:

13 “PART 8—RULES GOVERNING ASSOCIATION HEALTH  
 14 PLANS

15 **“SEC. 801. ASSOCIATION HEALTH PLANS.**

16 “(a) IN GENERAL.—For purposes of this part, the  
 17 term ‘association health plan’ means a group health  
 18 plan—

19 “(1) whose sponsor is (or is deemed under this  
 20 part to be) described in subsection (b); and

21 “(2) under which at least one option of health  
 22 insurance coverage offered by a health insurance  
 23 issuer (which may include, among other options,  
 24 managed care options, point of service options, and  
 25 preferred provider options) is provided to partici-

1 pants and beneficiaries, unless, for any plan year,  
2 such coverage remains unavailable to the plan de-  
3 spite good faith efforts exercised by the plan to se-  
4 cure such coverage.

5 “(b) SPONSORSHIP.—The sponsor of a group health  
6 plan is described in this subsection if such sponsor—

7 “(1) is organized and maintained in good faith,  
8 with a constitution and bylaws specifically stating its  
9 purpose and providing for periodic meetings on at  
10 least an annual basis, as a bona fide trade associa-  
11 tion, a bona fide industry association (including a  
12 rural electric cooperative association or a rural tele-  
13 phone cooperative association), a bona fide profes-  
14 sional association, or a bona fide chamber of com-  
15 merce (or similar bona fide business association, in-  
16 cluding a corporation or similar organization that  
17 operates on a cooperative basis (within the meaning  
18 of section 1381 of the Internal Revenue Code of  
19 1986)), for substantial purposes other than that of  
20 obtaining or providing medical care;

21 “(2) is established as a permanent entity which  
22 receives the active support of its members and col-  
23 lects from its members on a periodic basis dues or  
24 payments necessary to maintain eligibility for mem-  
25 bership in the sponsor; and

1           “(3) does not condition membership, such dues  
2           or payments, or coverage under the plan on the  
3           basis of health status-related factors with respect to  
4           the employees of its members (or affiliated mem-  
5           bers), or the dependents of such employees, and does  
6           not condition such dues or payments on the basis of  
7           group health plan participation.

8   Any sponsor consisting of an association of entities which  
9   meet the requirements of paragraphs (1), (2), and (3)  
10 shall be deemed to be a sponsor described in this sub-  
11 section.

12 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**  
13 **PLANS.**

14       “(a) IN GENERAL.—The applicable authority shall  
15 prescribe by regulation, through negotiated rulemaking, a  
16 procedure under which, subject to subsection (b), the ap-  
17 plicable authority shall certify association health plans  
18 which apply for certification as meeting the requirements  
19 of this part.

20       “(b) STANDARDS.—Under the procedure prescribed  
21 pursuant to subsection (a), in the case of an association  
22 health plan that provides at least one benefit option which  
23 does not consist of health insurance coverage, the applica-  
24 ble authority shall certify such plan as meeting the re-

1 requirements of this part only if the applicable authority is  
 2 satisfied that—

3 “(1) such certification—

4 “(A) is administratively feasible;

5 “(B) is not adverse to the interests of the  
 6 individuals covered under the plan; and

7 “(C) is protective of the rights and benefits  
 8 of the individuals covered under the plan; and

9 “(2) the applicable requirements of this part  
 10 are met (or, upon the date on which the plan is to  
 11 commence operations, will be met) with respect to  
 12 the plan.

13 “(c) REQUIREMENTS APPLICABLE TO CERTIFIED  
 14 PLANS.—An association health plan with respect to which  
 15 certification under this part is in effect shall meet the ap-  
 16 plicable requirements of this part, effective on the date  
 17 of certification (or, if later, on the date on which the plan  
 18 is to commence operations).

19 “(d) REQUIREMENTS FOR CONTINUED CERTIFI-  
 20 CATION.—The applicable authority may provide by regula-  
 21 tion, through negotiated rulemaking, for continued certifi-  
 22 cation of association health plans under this part.

23 “(e) CLASS CERTIFICATION FOR FULLY INSURED  
 24 PLANS.—The applicable authority shall establish a class  
 25 certification procedure for association health plans under



1 which all benefits consist of health insurance coverage.  
2 Under such procedure, the applicable authority shall pro-  
3 vide for the granting of certification under this part to  
4 the plans in each class of such association health plans  
5 upon appropriate filing under such procedure in connec-  
6 tion with plans in such class and payment of the pre-  
7 scribed fee under section 807(a).

8 “(f) CERTIFICATION OF SELF-INSURED ASSOCIATION  
9 HEALTH PLANS.—An association health plan which offers  
10 one or more benefit options which do not consist of health  
11 insurance coverage may be certified under this part only  
12 if such plan consists of any of the following:

13 “(1) a plan which offered such coverage on the  
14 date of the enactment of the Small Business Access  
15 and Choice for Entrepreneurs Act of 2003,

16 “(2) a plan under which the sponsor does not  
17 restrict membership to one or more trades and busi-  
18 nesses or industries and whose eligible participating  
19 employers represent a broad cross-section of trades  
20 and businesses or industries, or

21 “(3) a plan whose eligible participating employ-  
22 ers represent one or more trades or businesses, or  
23 one or more industries, which have been indicated as  
24 having average or above-average health insurance  
25 risk or health claims experience by reason of State

1 rate filings, denials of coverage, proposed premium  
2 rate levels, and other means demonstrated by such  
3 plan in accordance with regulations which the Sec-  
4 retary shall prescribe through negotiated rule-  
5 making, including (but not limited to) the following:  
6 agriculture; automobile dealerships; barbering and  
7 cosmetology; child care; construction; dance, theat-  
8 rical, and orchestra productions; disinfecting and  
9 pest control; eating and drinking establishments;  
10 fishing; hospitals; labor organizations; logging; man-  
11 ufacturing (metals); mining; medical and dental  
12 practices; medical laboratories; sanitary services;  
13 transportation (local and freight); and warehousing.

14 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**  
15 **BOARDS OF TRUSTEES.**

16 “(a) SPONSOR.—The requirements of this subsection  
17 are met with respect to an association health plan if the  
18 sponsor has met (or is deemed under this part to have  
19 met) the requirements of section 801(b) for a continuous  
20 period of not less than 3 years ending with the date of  
21 the application for certification under this part.

22 “(b) BOARD OF TRUSTEES.—The requirements of  
23 this subsection are met with respect to an association  
24 health plan if the following requirements are met:

1           “(1) FISCAL CONTROL.—The plan is operated,  
2           pursuant to a trust agreement, by a board of trust-  
3           ees which has complete fiscal control over the plan  
4           and which is responsible for all operations of the  
5           plan.

6           “(2) RULES OF OPERATION AND FINANCIAL  
7           CONTROLS.—The board of trustees has in effect  
8           rules of operation and financial controls, based on a  
9           3-year plan of operation, adequate to carry out the  
10          terms of the plan and to meet all requirements of  
11          this title applicable to the plan.

12          “(3) RULES GOVERNING RELATIONSHIP TO  
13          PARTICIPATING EMPLOYERS AND TO CONTRAC-  
14          TORS.—

15               “(A) IN GENERAL.—Except as provided in  
16               subparagraphs (B) and (C), the members of the  
17               board of trustees are individuals selected from  
18               individuals who are the owners, officers, direc-  
19               tors, or employees of the participating employ-  
20               ers or who are partners in the participating em-  
21               ployers and actively participate in the business.

22               “(B) LIMITATION.—

23                   “(i) GENERAL RULE.—Except as pro-  
24                   vided in clauses (ii) and (iii), no such  
25                   member is an owner, officer, director, or

1 employee of, or partner in, a contract ad-  
2 ministrator or other service provider to the  
3 plan.

4 “(ii) LIMITED EXCEPTION FOR PRO-  
5 VIDERS OF SERVICES SOLELY ON BEHALF  
6 OF THE SPONSOR.—Officers or employees  
7 of a sponsor which is a service provider  
8 (other than a contract administrator) to  
9 the plan may be members of the board if  
10 they constitute not more than 25 percent  
11 of the membership of the board and they  
12 do not provide services to the plan other  
13 than on behalf of the sponsor.

14 “(iii) TREATMENT OF PROVIDERS OF  
15 MEDICAL CARE.—In the case of a sponsor  
16 which is an association whose membership  
17 consists primarily of providers of medical  
18 care, clause (i) shall not apply in the case  
19 of any service provider described in sub-  
20 paragraph (A) who is a provider of medical  
21 care under the plan.

22 “(C) CERTAIN PLANS EXCLUDED.—Sub-  
23 paragraph (A) shall not apply to an association  
24 health plan which is in existence on the date of

1 the enactment of the Small Business Access  
2 and Choice for Entrepreneurs Act of 2003.

3 “(D) SOLE AUTHORITY.—The board has  
4 sole authority under the plan to approve appli-  
5 cations for participation in the plan and to con-  
6 tract with a service provider to administer the  
7 day-to-day affairs of the plan.

8 “(c) TREATMENT OF FRANCHISE NETWORKS.—In  
9 the case of a group health plan which is established and  
10 maintained by a franchiser for a franchise network con-  
11 sisting of its franchisees—

12 “(1) the requirements of subsection (a) and sec-  
13 tion 801(a)(1) shall be deemed met if such require-  
14 ments would otherwise be met if the franchiser were  
15 deemed to be the sponsor referred to in section  
16 801(b), such network were deemed to be an associa-  
17 tion described in section 801(b), and each franchisee  
18 were deemed to be a member (of the association and  
19 the sponsor) referred to in section 801(b); and

20 “(2) the requirements of section 804(a)(1) shall  
21 be deemed met.

22 The Secretary may by regulation, through negotiated rule-  
23 making, define for purposes of this subsection the terms  
24 ‘franchiser’, ‘franchise network’, and ‘franchisee’.

25 “(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

1           “(1) IN GENERAL.—In the case of a group  
2 health plan described in paragraph (2)—

3           “(A) the requirements of subsection (a)  
4 and section 801(a)(1) shall be deemed met;

5           “(B) the joint board of trustees shall be  
6 deemed a board of trustees with respect to  
7 which the requirements of subsection (b) are  
8 met; and

9           “(C) the requirements of section 804 shall  
10 be deemed met.

11           “(2) REQUIREMENTS.—A group health plan is  
12 described in this paragraph if—

13           “(A) the plan is a multiemployer plan; or

14           “(B) the plan is in existence on April 1,  
15 1997, and would be described in section  
16 3(40)(A)(i) but solely for the failure to meet  
17 the requirements of section 3(40)(C)(ii).

18 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**  
19 **MENTS.**

20           “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The  
21 requirements of this subsection are met with respect to  
22 an association health plan if, under the terms of the  
23 plan—

24           “(1) each participating employer must be—

25           “(A) a member of the sponsor;

1 “(B) the sponsor; or

2 “(C) an affiliated member of the sponsor  
3 with respect to which the requirements of sub-  
4 section (b) are met;

5 except that, in the case of a sponsor which is a pro-  
6 fessional association or other individual-based asso-  
7 ciation, if at least one of the officers, directors, or  
8 employees of an employer, or at least one of the in-  
9 dividuals who are partners in an employer and who  
10 actively participates in the business, is a member or  
11 such an affiliated member of the sponsor, partici-  
12 pating employers may also include such employer;  
13 and

14 “(2) all individuals commencing coverage under  
15 the plan after certification under this part must  
16 be—

17 “(A) active or retired owners (including  
18 self-employed individuals), officers, directors, or  
19 employees of, or partners in, participating em-  
20 ployers; or

21 “(B) the beneficiaries of individuals de-  
22 scribed in subparagraph (A).

23 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-  
24 PLOYEES.—In the case of an association health plan in  
25 existence on the date of the enactment of the Small Busi-

1 ness Access and Choice for Entrepreneurs Act of 2003,  
2 an affiliated member of the sponsor of the plan may be  
3 offered coverage under the plan as a participating em-  
4 ployer only if—

5           “(1) the affiliated member was an affiliated  
6 member on the date of certification under this part;  
7 or

8           “(2) during the 12-month period preceding the  
9 date of the offering of such coverage, the affiliated  
10 member has not maintained or contributed to a  
11 group health plan with respect to any of its employ-  
12 ees who would otherwise be eligible to participate in  
13 such association health plan.

14       “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-  
15 quirements of this subsection are met with respect to an  
16 association health plan if, under the terms of the plan,  
17 no participating employer may provide health insurance  
18 coverage in the individual market for any employee not  
19 covered under the plan which is similar to the coverage  
20 contemporaneously provided to employees of the employer  
21 under the plan, if such exclusion of the employee from cov-  
22 erage under the plan is based on a health status-related  
23 factor with respect to the employee and such employee  
24 would, but for such exclusion on such basis, be eligible  
25 for coverage under the plan.



1       “(d) PROHIBITION OF DISCRIMINATION AGAINST  
 2 EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICI-  
 3 PATE.—The requirements of this subsection are met with  
 4 respect to an association health plan if—

5           “(1) under the terms of the plan, all employers  
 6 meeting the preceding requirements of this section  
 7 are eligible to qualify as participating employers for  
 8 all geographically available coverage options, unless,  
 9 in the case of any such employer, participation or  
 10 contribution requirements of the type referred to in  
 11 section 2711 of the Public Health Service Act are  
 12 not met;

13           “(2) upon request, any employer eligible to par-  
 14 ticipate is furnished information regarding all cov-  
 15 erage options available under the plan; and

16           “(3) the applicable requirements of sections  
 17 701, 702, and 703 are met with respect to the plan.

18 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**  
 19 **DOCUMENTS, CONTRIBUTION RATES, AND**  
 20 **BENEFIT OPTIONS.**

21       “(a) IN GENERAL.—The requirements of this section  
 22 are met with respect to an association health plan if the  
 23 following requirements are met:

24           “(1) CONTENTS OF GOVERNING INSTRU-  
 25 MENTS.—The instruments governing the plan in-

1       clude a written instrument, meeting the require-  
2       ments of an instrument required under section  
3       402(a)(1), which—

4               “(A) provides that the board of trustees  
5       serves as the named fiduciary required for plans  
6       under section 402(a)(1) and serves in the ca-  
7       pacity of a plan administrator (referred to in  
8       section 3(16)(A));

9               “(B) provides that the sponsor of the plan  
10      is to serve as plan sponsor (referred to in sec-  
11      tion 3(16)(B)); and

12              “(C) incorporates the requirements of sec-  
13      tion 806.

14              “(2) CONTRIBUTION RATES MUST BE NON-  
15      DISCRIMINATORY.—

16              “(A) The contribution rates for any par-  
17      ticipating small employer do not vary on the  
18      basis of the claims experience of such employer  
19      and do not vary on the basis of the type of  
20      business or industry in which such employer is  
21      engaged.

22              “(B) Nothing in this title or any other pro-  
23      vision of law shall be construed to preclude an  
24      association health plan, or a health insurance  
25      issuer offering health insurance coverage in

1 connection with an association health plan,  
2 from—

3 “(i) setting contribution rates based  
4 on the claims experience of the plan; or

5 “(ii) varying contribution rates for  
6 small employers in a State to the extent  
7 that such rates could vary using the same  
8 methodology employed in such State for  
9 regulating premium rates in the small  
10 group market with respect to health insur-  
11 ance coverage offered in connection with  
12 bona fide associations (within the meaning  
13 of section 2791(d)(3) of the Public Health  
14 Service Act),

15 subject to the requirements of section 702(b)  
16 relating to contribution rates.

17 “(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If  
18 any benefit option under the plan does not consist  
19 of health insurance coverage, the plan has as of the  
20 beginning of the plan year not fewer than 1,000 participants and beneficiaries.

23 “(4) MARKETING REQUIREMENTS.—

24 “(A) IN GENERAL.—If a benefit option  
25 which consists of health insurance coverage is

1           offered under the plan, State-licensed insurance  
2           agents shall be used to distribute to small em-  
3           ployers coverage which does not consist of  
4           health insurance coverage in a manner com-  
5           parable to the manner in which such agents are  
6           used to distribute health insurance coverage.

7           “(B)       STATE-LICENSED       INSURANCE  
8           AGENTS.—For purposes of subparagraph (A),  
9           the term ‘State-licensed insurance agents’  
10          means one or more agents who are licensed in  
11          a State and are subject to the laws of such  
12          State relating to licensure, qualification, test-  
13          ing, examination, and continuing education of  
14          persons authorized to offer, sell, or solicit  
15          health insurance coverage in such State.

16          “(5)       REGULATORY       REQUIREMENTS.—Such  
17          other requirements as the applicable authority deter-  
18          mines are necessary to carry out the purposes of this  
19          part, which shall be prescribed by the applicable au-  
20          thority by regulation through negotiated rulemaking.

21          “(b) HEALTH BENEFIT OPTIONS UNDER AN ASSO-  
22          CIATION HEALTH PLAN.—

23          “(1) EXAMPLES OF TYPES OF COVERAGE.—The  
24          health benefits coverage made available through an  
25          association health plan may include, but is not lim-

1       ited to, any of the following if it meets the other ap-  
2       plicable requirements of this title:

3               “(A) Coverage through a health mainte-  
4       nance organization.

5               “(B) Coverage in connection with a pre-  
6       ferred provider organization.

7               “(C) Coverage in connection with a li-  
8       censed provider-sponsored organization.

9               “(D) Indemnity coverage through an insur-  
10      ance company.

11              “(E) Coverage offered in connection with a  
12      contribution into a medical savings account or  
13      flexible spending account.

14              “(F) Coverage that includes a point-of-  
15      service option.

16              “(G) Any combination of such types of  
17      coverage.

18              “(2) HEALTH INSURANCE COVERAGE OP-  
19      TIONS.—

20              “(A) IN GENERAL.—An association health  
21      plan shall include a minimum of 4 health insur-  
22      ance coverage options. At least 1 option shall be  
23      a non network option. At least 2 options shall  
24      meet all applicable State benefit mandates.

1           “(B) MODEL BENEFITS PACKAGE.—The  
2           Secretary in consultation with the National As-  
3           sociation of Insurance Commissioners shall de-  
4           velop a model benefits package for health insur-  
5           ance coverage not later than one year after the  
6           date of the enactment of the Consensus Health  
7           Care Access and Choice Act of 2003.

8           “(C) EXCEPTION TO GENERAL RULE.—An  
9           association health plan may offer 2 options that  
10          meet the requirements of the model benefits  
11          package in lieu of the State benefit mandate of-  
12          ferings required under subparagraph (A).

13          “(3) PERMITTING ASSOCIATION HEALTH PLANS  
14          TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO RE-  
15          FLECT RELATIVE RISK OF ENROLLEES.—Nothing in  
16          this section shall be construed as precluding an asso-  
17          ciation health plan from providing for adjustments  
18          in amounts distributed among the health insurance  
19          issuers offering health benefits coverage through the  
20          association health plan based on factors such as the  
21          relative health care risk of members enrolled under  
22          the coverage offered by the different issuers.

23          “(4) CONSTRUCTION.—Except as provided in  
24          subparagraph (2), nothing in this part or any provi-  
25          sion of State law (as defined in section 514(c)(1))

1 shall be construed to preclude an association health  
2 plan, or a health insurance issuer offering health in-  
3 surance coverage in connection with an association  
4 health plan, from exercising its sole discretion in se-  
5 lecting the specific items and services consisting of  
6 medical care to be included as benefits under such  
7 plan or coverage, except (subject to section 514) in  
8 the case of any law to the extent that it (1) prohibits  
9 an exclusion of a specific disease from such cov-  
10 erage, or (2) is not preempted under section  
11 731(a)(1) with respect to matters governed by sec-  
12 tion 711 or 712.

13 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**  
14 **FOR SOLVENCY FOR PLANS PROVIDING**  
15 **HEALTH BENEFITS IN ADDITION TO HEALTH**  
16 **INSURANCE COVERAGE.**

17 “(a) IN GENERAL.—The requirements of this section  
18 are met with respect to an association health plan if—

19 “(1) the benefits under the plan consist solely  
20 of health insurance coverage; or

21 “(2) if the plan provides any additional benefit  
22 options which do not consist of health insurance cov-  
23 erage, the plan—

24 “(A) establishes and maintains reserves  
25 with respect to such additional benefit options,

1 in amounts recommended by the qualified actu-  
2 ary, consisting of—

3 “(i) a reserve sufficient for unearned  
4 contributions;

5 “(ii) a reserve sufficient for benefit li-  
6 abilities which have been incurred, which  
7 have not been satisfied, and for which risk  
8 of loss has not yet been transferred, and  
9 for expected administrative costs with re-  
10 spect to such benefit liabilities;

11 “(iii) a reserve sufficient for any other  
12 obligations of the plan; and

13 “(iv) a reserve sufficient for a margin  
14 of error and other fluctuations, taking into  
15 account the specific circumstances of the  
16 plan; and

17 “(B) establishes and maintains aggregate  
18 and specific excess/stop loss insurance and sol-  
19 vency indemnification, with respect to such ad-  
20 ditional benefit options for which risk of loss  
21 has not yet been transferred, as follows:

22 “(i) The plan shall secure aggregate  
23 excess/stop loss insurance for the plan  
24 with an attachment point which is not  
25 greater than 125 percent of expected gross



1 annual claims. The applicable authority  
2 may by regulation, through negotiated  
3 rulemaking, provide for upward adjust-  
4 ments in the amount of such percentage in  
5 specified circumstances in which the plan  
6 specifically provides for and maintains re-  
7 serves in excess of the amounts required  
8 under subparagraph (A).

9 “(ii) The plan shall secure specific ex-  
10 cess/stop loss insurance for the plan with  
11 an attachment point which is at least equal  
12 to an amount recommended by the plan’s  
13 qualified actuary (but not more than  
14 \$175,000). The applicable authority may  
15 by regulation, through negotiated rule-  
16 making, provide for adjustments in the  
17 amount of such insurance in specified cir-  
18 cumstances in which the plan specifically  
19 provides for and maintains reserves in ex-  
20 cess of the amounts required under sub-  
21 paragraph (A).

22 “(iii) The plan shall secure indem-  
23 nification insurance for any claims which  
24 the plan is unable to satisfy by reason of  
25 a plan termination.

1 Any regulations prescribed by the applicable authority  
 2 pursuant to clause (i) or (ii) of subparagraph (B) may  
 3 allow for such adjustments in the required levels of excess/  
 4 stop loss insurance as the qualified actuary may rec-  
 5 ommend, taking into account the specific circumstances  
 6 of the plan.

7 “(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS  
 8 RESERVES.—In the case of any association health plan de-  
 9 scribed in subsection (a)(2), the requirements of this sub-  
 10 section are met if the plan establishes and maintains sur-  
 11 plus in an amount at least equal to—

12 “(1) \$500,000, or

13 “(2) such greater amount (but not greater than  
 14 \$2,000,000) as may be set forth in regulations pre-  
 15 scribed by the applicable authority through nego-  
 16 tiated rulemaking, based on the level of aggregate  
 17 and specific excess/stop loss insurance provided with  
 18 respect to such plan.

19 “(c) ADDITIONAL REQUIREMENTS.—In the case of  
 20 any association health plan described in subsection (a)(2),  
 21 the applicable authority may provide such additional re-  
 22 quirements relating to reserves and excess/stop loss insur-  
 23 ance as the applicable authority considers appropriate.  
 24 Such requirements may be provided by regulation, through

1 negotiated rulemaking, with respect to any such plan or  
2 any class of such plans.

3 “(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-  
4 ANCE.—The applicable authority may provide for adjust-  
5 ments to the levels of reserves otherwise required under  
6 subsections (a) and (b) with respect to any plan or class  
7 of plans to take into account excess/stop loss insurance  
8 provided with respect to such plan or plans.

9 “(e) ALTERNATIVE MEANS OF COMPLIANCE.—The  
10 applicable authority may permit an association health plan  
11 described in subsection (a)(2) to substitute, for all or part  
12 of the requirements of this section (except subsection  
13 (a)(2)(B)(iii)), such security, guarantee, hold-harmless ar-  
14 rangement, or other financial arrangement as the applica-  
15 ble authority determines to be adequate to enable the plan  
16 to fully meet all its financial obligations on a timely basis  
17 and is otherwise no less protective of the interests of par-  
18 ticipants and beneficiaries than the requirements for  
19 which it is substituted. The applicable authority may take  
20 into account, for purposes of this subsection, evidence pro-  
21 vided by the plan or sponsor which demonstrates an as-  
22 sumption of liability with respect to the plan. Such evi-  
23 dence may be in the form of a contract of indemnification,  
24 lien, bonding, insurance, letter of credit, recourse under  
25 applicable terms of the plan in the form of assessments

1 of participating employers, security, or other financial ar-  
2 rangement.

3 “(f) MEASURES TO ENSURE CONTINUED PAYMENT  
4 OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

5 “(1) PAYMENTS BY CERTAIN PLANS TO ASSO-  
6 CIATION HEALTH PLAN FUND.—

7 “(A) IN GENERAL.—In the case of an as-  
8 sociation health plan described in subsection  
9 (a)(2), the requirements of this subsection are  
10 met if the plan makes payments into the Asso-  
11 ciation Health Plan Fund under this subpara-  
12 graph when they are due. Such payments shall  
13 consist of annual payments in the amount of  
14 \$5,000, and, in addition to such annual pay-  
15 ments, such supplemental payments as the Sec-  
16 retary may determine to be necessary under  
17 paragraph (2). Payments under this paragraph  
18 are payable to the Fund at the time determined  
19 by the Secretary. Initial payments are due in  
20 advance of certification under this part. Pay-  
21 ments shall continue to accrue until a plan’s as-  
22 sets are distributed pursuant to a termination  
23 procedure.

24 “(B) PENALTIES FOR FAILURE TO MAKE  
25 PAYMENTS.—If any payment is not made by a

1 plan when it is due, a late payment charge of  
2 not more than 100 percent of the payment  
3 which was not timely paid shall be payable by  
4 the plan to the Fund.

5 “(C) CONTINUED DUTY OF THE SEC-  
6 RETARY.—The Secretary shall not cease to  
7 carry out the provisions of paragraph (2) on ac-  
8 count of the failure of a plan to pay any pay-  
9 ment when due.

10 “(2) PAYMENTS BY SECRETARY TO CONTINUE  
11 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-  
12 DEMNIFICATION INSURANCE COVERAGE FOR CER-  
13 TAIN PLANS.—In any case in which the applicable  
14 authority determines that there is, or that there is  
15 reason to believe that there will be: (A) a failure to  
16 take necessary corrective actions under section  
17 809(a) with respect to an association health plan de-  
18 scribed in subsection (a)(2); or (B) a termination of  
19 such a plan under section 809(b) or 810(b)(8) (and,  
20 if the applicable authority is not the Secretary, cer-  
21 tifies such determination to the Secretary), the Sec-  
22 retary shall determine the amounts necessary to  
23 make payments to an insurer (designated by the  
24 Secretary) to maintain in force excess/stop loss in-  
25 surance coverage or indemnification insurance cov-

1        erage for such plan, if the Secretary determines that  
2        there is a reasonable expectation that, without such  
3        payments, claims would not be satisfied by reason of  
4        termination of such coverage. The Secretary shall, to  
5        the extent provided in advance in appropriation  
6        Acts, pay such amounts so determined to the insurer  
7        designated by the Secretary.

8            “(3) ASSOCIATION HEALTH PLAN FUND.—

9            “(A) IN GENERAL.—There is established  
10        on the books of the Treasury a fund to be  
11        known as the ‘Association Health Plan Fund’.  
12        The Fund shall be available for making pay-  
13        ments pursuant to paragraph (2). The Fund  
14        shall be credited with payments received pursu-  
15        ant to paragraph (1)(A), penalties received pur-  
16        suant to paragraph (1)(B); and earnings on in-  
17        vestments of amounts of the Fund under sub-  
18        paragraph (B).

19        “(B) INVESTMENT.—Whenever the Sec-  
20        retary determines that the moneys of the fund  
21        are in excess of current needs, the Secretary  
22        may request the investment of such amounts as  
23        the Secretary determines advisable by the Sec-  
24        retary of the Treasury in obligations issued or  
25        guaranteed by the United States.

1       “(g) EXCESS/STOP LOSS INSURANCE.—For pur-  
2 poses of this section—

3               “(1) AGGREGATE EXCESS/STOP LOSS INSUR-  
4 ANCE.—The term ‘aggregate excess/stop loss insur-  
5 ance’ means, in connection with an association  
6 health plan, a contract—

7                       “(A) under which an insurer (meeting such  
8 minimum standards as the applicable authority  
9 may prescribe by regulation through negotiated  
10 rulemaking) provides for payment to the plan  
11 with respect to aggregate claims under the plan  
12 in excess of an amount or amounts specified in  
13 such contract;

14                      “(B) which is guaranteed renewable; and

15                      “(C) which allows for payment of pre-  
16 miums by any third party on behalf of the in-  
17 sured plan.

18               “(2) SPECIFIC EXCESS/STOP LOSS INSUR-  
19 ANCE.—The term ‘specific excess/stop loss insur-  
20 ance’ means, in connection with an association  
21 health plan, a contract—

22                      “(A) under which an insurer (meeting such  
23 minimum standards as the applicable authority  
24 may prescribe by regulation through negotiated  
25 rulemaking) provides for payment to the plan

1 with respect to claims under the plan in connec-  
2 tion with a covered individual in excess of an  
3 amount or amounts specified in such contract  
4 in connection with such covered individual;

5 “(B) which is guaranteed renewable; and

6 “(C) which allows for payment of pre-  
7 miums by any third party on behalf of the in-  
8 sured plan.

9 “(h) INDEMNIFICATION INSURANCE.—For purposes  
10 of this section, the term ‘indemnification insurance’  
11 means, in connection with an association health plan, a  
12 contract—

13 “(1) under which an insurer (meeting such min-  
14 imum standards as the applicable authority may pre-  
15 scribe through negotiated rulemaking) provides for  
16 payment to the plan with respect to claims under the  
17 plan which the plan is unable to satisfy by reason  
18 of a termination pursuant to section 809(b) (relating  
19 to mandatory termination);

20 “(2) which is guaranteed renewable and  
21 noncancellable for any reason (except as the applica-  
22 ble authority may prescribe by regulation through  
23 negotiated rulemaking); and

24 “(3) which allows for payment of premiums by  
25 any third party on behalf of the insured plan.



1       “(i) RESERVES.—For purposes of this section, the  
2 term ‘reserves’ means, in connection with an association  
3 health plan, plan assets which meet the fiduciary stand-  
4 ards under part 4 and such additional requirements re-  
5 garding liquidity as the applicable authority may prescribe  
6 through negotiated rulemaking.

7       “(j) SOLVENCY STANDARDS WORKING GROUP.—

8               “(1) IN GENERAL.—Within 90 days after the  
9 date of the enactment of the Small Business Access  
10 and Choice for Entrepreneurs Act of 2003, the ap-  
11 plicable authority shall establish a Solvency Stand-  
12 ards Working Group. In prescribing the initial regu-  
13 lations under this section, the applicable authority  
14 shall take into account the recommendations of such  
15 Working Group.

16               “(2) MEMBERSHIP.—The Working Group shall  
17 consist of not more than 15 members appointed by  
18 the applicable authority. The applicable authority  
19 shall include among persons invited to membership  
20 on the Working Group at least one of each of the  
21 following:

22                       “(A) a representative of the National Asso-  
23 ciation of Insurance Commissioners;

24                       “(B) a representative of the American  
25 Academy of Actuaries;

1           “(C) a representative of the State govern-  
2           ments, or their interests;

3           “(D) a representative of existing self-in-  
4           sured arrangements, or their interests;

5           “(E) a representative of associations of the  
6           type referred to in section 801(b)(1), or their  
7           interests; and

8           “(F) a representative of multiemployer  
9           plans that are group health plans, or their in-  
10          terests.

11 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**  
12 **LATED REQUIREMENTS.**

13          “(a) FILING FEE.—Under the procedure prescribed  
14 pursuant to section 802(a), an association health plan  
15 shall pay to the applicable authority at the time of filing  
16 an application for certification under this part a filing fee  
17 in the amount of \$5,000, which shall be available in the  
18 case of the Secretary, to the extent provided in appropria-  
19 tion Acts, for the sole purpose of administering the certifi-  
20 cation procedures applicable with respect to association  
21 health plans.

22          “(b) INFORMATION TO BE INCLUDED IN APPLICA-  
23 TION FOR CERTIFICATION.—An application for certifi-  
24 cation under this part meets the requirements of this sec-  
25 tion only if it includes, in a manner and form which shall

1 be prescribed by the applicable authority through nego-  
2 tiated rulemaking, at least the following information:

3 “(1) IDENTIFYING INFORMATION.—The names  
4 and addresses of—

5 “(A) the sponsor; and

6 “(B) the members of the board of trustees  
7 of the plan.

8 “(2) STATES IN WHICH PLAN INTENDS TO DO  
9 BUSINESS.—The States in which participants and  
10 beneficiaries under the plan are to be located and  
11 the number of them expected to be located in each  
12 such State.

13 “(3) BONDING REQUIREMENTS.—Evidence pro-  
14 vided by the board of trustees that the bonding re-  
15 quirements of section 412 will be met as of the date  
16 of the application or (if later) commencement of op-  
17 erations.

18 “(4) PLAN DOCUMENTS.—A copy of the docu-  
19 ments governing the plan (including any bylaws and  
20 trust agreements), the summary plan description,  
21 and other material describing the benefits that will  
22 be provided to participants and beneficiaries under  
23 the plan.

24 “(5) AGREEMENTS WITH SERVICE PRO-  
25 VIDERS.—A copy of any agreements between the

1 plan and contract administrators and other service  
2 providers.

3 “(6) FUNDING REPORT.—In the case of asso-  
4 ciation health plans providing benefits options in ad-  
5 dition to health insurance coverage, a report setting  
6 forth information with respect to such additional  
7 benefit options determined as of a date within the  
8 120-day period ending with the date of the applica-  
9 tion, including the following:

10 “(A) RESERVES.—A statement, certified  
11 by the board of trustees of the plan, and a  
12 statement of actuarial opinion, signed by a  
13 qualified actuary, that all applicable require-  
14 ments of section 806 are or will be met in ac-  
15 cordance with regulations which the applicable  
16 authority shall prescribe through negotiated  
17 rulemaking.

18 “(B) ADEQUACY OF CONTRIBUTION  
19 RATES.—A statement of actuarial opinion,  
20 signed by a qualified actuary, which sets forth  
21 a description of the extent to which contribution  
22 rates are adequate to provide for the payment  
23 of all obligations and the maintenance of re-  
24 quired reserves under the plan for the 12-  
25 month period beginning with such date within

1 such 120-day period, taking into account the  
2 expected coverage and experience of the plan. If  
3 the contribution rates are not fully adequate,  
4 the statement of actuarial opinion shall indicate  
5 the extent to which the rates are inadequate  
6 and the changes needed to ensure adequacy.

7 “(C) CURRENT AND PROJECTED VALUE OF  
8 ASSETS AND LIABILITIES.—A statement of ac-  
9 tuarial opinion signed by a qualified actuary,  
10 which sets forth the current value of the assets  
11 and liabilities accumulated under the plan and  
12 a projection of the assets, liabilities, income,  
13 and expenses of the plan for the 12-month pe-  
14 riod referred to in subparagraph (B). The in-  
15 come statement shall identify separately the  
16 plan’s administrative expenses and claims.

17 “(D) COSTS OF COVERAGE TO BE  
18 CHARGED AND OTHER EXPENSES.—A state-  
19 ment of the costs of coverage to be charged, in-  
20 cluding an itemization of amounts for adminis-  
21 tration, reserves, and other expenses associated  
22 with the operation of the plan.

23 “(E) OTHER INFORMATION.—Any other  
24 information as may be determined by the appli-  
25 cable authority, by regulation through nego-

1           tiated rulemaking, as necessary to carry out the  
2           purposes of this part.

3           “(c) FILING NOTICE OF CERTIFICATION WITH  
4 STATES.—A certification granted under this part to an  
5 association health plan shall not be effective unless written  
6 notice of such certification is filed with the applicable  
7 State authority of each State in which at least 25 percent  
8 of the participants and beneficiaries under the plan are  
9 located. For purposes of this subsection, an individual  
10 shall be considered to be located in the State in which a  
11 known address of such individual is located or in which  
12 such individual is employed.

13           “(d) NOTICE OF MATERIAL CHANGES.—In the case  
14 of any association health plan certified under this part,  
15 descriptions of material changes in any information which  
16 was required to be submitted with the application for the  
17 certification under this part shall be filed in such form  
18 and manner as shall be prescribed by the applicable au-  
19 thority by regulation through negotiated rulemaking. The  
20 applicable authority may require by regulation, through  
21 negotiated rulemaking, prior notice of material changes  
22 with respect to specified matters which might serve as the  
23 basis for suspension or revocation of the certification.

24           “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-  
25 SOCIATION HEALTH PLANS.—An association health plan

1 certified under this part which provides benefit options in  
2 addition to health insurance coverage for such plan year  
3 shall meet the requirements of section 103 by filing an  
4 annual report under such section which shall include infor-  
5 mation described in subsection (b)(6) with respect to the  
6 plan year and, notwithstanding section 104(a)(1)(A), shall  
7 be filed with the applicable authority not later than 90  
8 days after the close of the plan year (or on such later date  
9 as may be prescribed by the applicable authority). The ap-  
10 plicable authority may require by regulation through nego-  
11 tiated rulemaking such interim reports as it considers ap-  
12 propriate.

13       “(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The  
14 board of trustees of each association health plan which  
15 provides benefits options in addition to health insurance  
16 coverage and which is applying for certification under this  
17 part or is certified under this part shall engage, on behalf  
18 of all participants and beneficiaries, a qualified actuary  
19 who shall be responsible for the preparation of the mate-  
20 rials comprising information necessary to be submitted by  
21 a qualified actuary under this part. The qualified actuary  
22 shall utilize such assumptions and techniques as are nec-  
23 essary to enable such actuary to form an opinion as to  
24 whether the contents of the matters reported under this  
25 part—

6 The opinion by the qualified actuary shall be made with  
7 respect to, and shall be made a part of, the annual report.

10       “Except as provided in section 809(b), an association  
11 health plan which is or has been certified under this part  
12 may terminate (upon or at any time after cessation of ac-  
13 cruals in benefit liabilities) only if the board of trustees—

19 “(2) develops a plan for winding up the affairs  
20 of the plan in connection with such termination in  
21 a manner which will result in timely payment of all  
22 benefits for which the plan is obligated; and

•HR 3423 IH



1 Actions required under this section shall be taken in such  
2 form and manner as may be prescribed by the applicable  
3 authority by regulation through negotiated rulemaking.

4 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.**  
5

6       “(a) ACTIONS TO AVOID DEPLETION OF RE-  
7 SERVES.—An association health plan which is certified  
8 under this part and which provides benefits other than  
9 health insurance coverage shall continue to meet the re-  
10 quirements of section 806, irrespective of whether such  
11 certification continues in effect. The board of trustees of  
12 such plan shall determine quarterly whether the require-  
13 ments of section 806 are met. In any case in which the  
14 board determines that there is reason to believe that there  
15 is or will be a failure to meet such requirements, or the  
16 applicable authority makes such a determination and so  
17 notifies the board, the board shall immediately notify the  
18 qualified actuary engaged by the plan, and such actuary  
19 shall, not later than the end of the next following month,  
20 make such recommendations to the board for corrective  
21 action as the actuary determines necessary to ensure com-  
22 pliance with section 806. Not later than 30 days after re-  
23 ceiving from the actuary recommendations for corrective  
24 actions, the board shall notify the applicable authority (in  
25 such form and manner as the applicable authority may

1 prescribe by regulation through negotiated rulemaking) of  
2 such recommendations of the actuary for corrective action,  
3 together with a description of the actions (if any) that the  
4 board has taken or plans to take in response to such rec-  
5 ommendations. The board shall thereafter report to the  
6 applicable authority, in such form and frequency as the  
7 applicable authority may specify to the board, regarding  
8 corrective action taken by the board until the requirements  
9 of section 806 are met.

10 “(b) MANDATORY TERMINATION.—In any case in  
11 which—

12 “(1) the applicable authority has been notified  
13 under subsection (a) of a failure of an association  
14 health plan which is or has been certified under this  
15 part and is described in section 806(a)(2) to meet  
16 the requirements of section 806 and has not been  
17 notified by the board of trustees of the plan that  
18 corrective action has restored compliance with such  
19 requirements; and

20 “(2) the applicable authority determines that  
21 there is a reasonable expectation that the plan will  
22 continue to fail to meet the requirements of section  
23 806,

24 the board of trustees of the plan shall, at the direction  
25 of the applicable authority, terminate the plan and, in the

1 course of the termination, take such actions as the appli-  
 2 cable authority may require, including satisfying any  
 3 claims referred to in section 806(a)(2)(B)(iii) and recov-  
 4 ering for the plan any liability under subsection  
 5 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure  
 6 that the affairs of the plan will be, to the maximum extent  
 7 possible, wound up in a manner which will result in timely  
 8 provision of all benefits for which the plan is obligated.

9 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**  
 10 **VENT ASSOCIATION HEALTH PLANS PRO-**  
 11 **VIDING HEALTH BENEFITS IN ADDITION TO**  
 12 **HEALTH INSURANCE COVERAGE.**

13 “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR  
 14 INSOLVENT PLANS.—Whenever the Secretary determines  
 15 that an association health plan which is or has been cer-  
 16 tified under this part and which is described in section  
 17 806(a)(2) will be unable to provide benefits when due or  
 18 is otherwise in a financially hazardous condition, as shall  
 19 be defined by the Secretary by regulation through nego-  
 20 tiated rulemaking, the Secretary shall, upon notice to the  
 21 plan, apply to the appropriate United States district court  
 22 for appointment of the Secretary as trustee to administer  
 23 the plan for the duration of the insolvency. The plan may  
 24 appear as a party and other interested persons may inter-  
 25 vene in the proceedings at the discretion of the court. The

1 court shall appoint such Secretary trustee if the court de-  
2 termines that the trusteeship is necessary to protect the  
3 interests of the participants and beneficiaries or providers  
4 of medical care or to avoid any unreasonable deterioration  
5 of the financial condition of the plan. The trusteeship of  
6 such Secretary shall continue until the conditions de-  
7 scribed in the first sentence of this subsection are rem-  
8 edied or the plan is terminated.

9 “(b) POWERS AS TRUSTEE.—The Secretary, upon  
10 appointment as trustee under subsection (a), shall have  
11 the power—

12 “(1) to do any act authorized by the plan, this  
13 title, or other applicable provisions of law to be done  
14 by the plan administrator or any trustee of the plan;

15 “(2) to require the transfer of all (or any part)  
16 of the assets and records of the plan to the Sec-  
17 retary as trustee;

18 “(3) to invest any assets of the plan which the  
19 Secretary holds in accordance with the provisions of  
20 the plan, regulations prescribed by the Secretary  
21 through negotiated rulemaking, and applicable provi-  
22 sions of law;

23 “(4) to require the sponsor, the plan adminis-  
24 trator, any participating employer, and any employee  
25 organization representing plan participants to fur-

1        nish any information with respect to the plan which  
2        the Secretary as trustee may reasonably need in  
3        order to administer the plan;

4            “(5) to collect for the plan any amounts due the  
5        plan and to recover reasonable expenses of the trust-  
6        eeship;

7            “(6) to commence, prosecute, or defend on be-  
8        half of the plan any suit or proceeding involving the  
9        plan;

10          “(7) to issue, publish, or file such notices, state-  
11        ments, and reports as may be required by the Sec-  
12        retary by regulation through negotiated rulemaking  
13        or required by any order of the court;

14          “(8) to terminate the plan (or provide for its  
15        termination accordance with section 809(b)) and liq-  
16        uidate the plan assets, to restore the plan to the re-  
17        sponsibility of the sponsor, or to continue the trust-  
18        eeship;

19          “(9) to provide for the enrollment of plan par-  
20        ticipants and beneficiaries under appropriate cov-  
21        erage options; and

22          “(10) to do such other acts as may be nec-  
23        essary to comply with this title or any order of the  
24        court and to protect the interests of plan partici-

1       pants and beneficiaries and providers of medical  
2       care.

3       “(c) NOTICE OF APPOINTMENT.—As soon as prac-  
4       ticable after the Secretary’s appointment as trustee, the  
5       Secretary shall give notice of such appointment to—

6               “(1) the sponsor and plan administrator;

7               “(2) each participant;

8               “(3) each participating employer; and

9               “(4) if applicable, each employee organization  
10       which, for purposes of collective bargaining, rep-  
11       resents plan participants.

12       “(d) ADDITIONAL DUTIES.—Except to the extent in-  
13       consistent with the provisions of this title, or as may be  
14       otherwise ordered by the court, the Secretary, upon ap-  
15       pointment as trustee under this section, shall be subject  
16       to the same duties as those of a trustee under section 704  
17       of title 11, United States Code, and shall have the duties  
18       of a fiduciary for purposes of this title.

19       “(e) OTHER PROCEEDINGS.—An application by the  
20       Secretary under this subsection may be filed notwith-  
21       standing the pendency in the same or any other court of  
22       any bankruptcy, mortgage foreclosure, or equity receiver-  
23       ship proceeding, or any proceeding to reorganize, conserve,  
24       or liquidate such plan or its property, or any proceeding  
25       to enforce a lien against property of the plan.

1 “(f) JURISDICTION OF COURT.—

2 “(1) IN GENERAL.—Upon the filing of an appli-  
3 cation for the appointment as trustee or the issuance  
4 of a decree under this section, the court to which the  
5 application is made shall have exclusive jurisdiction  
6 of the plan involved and its property wherever lo-  
7 cated with the powers, to the extent consistent with  
8 the purposes of this section, of a court of the United  
9 States having jurisdiction over cases under chapter  
10 11 of title 11, United States Code. Pending an adju-  
11 dication under this section such court shall stay, and  
12 upon appointment by it of the Secretary as trustee,  
13 such court shall continue the stay of, any pending  
14 mortgage foreclosure, equity receivership, or other  
15 proceeding to reorganize, conserve, or liquidate the  
16 plan, the sponsor, or property of such plan or spon-  
17 sor, and any other suit against any receiver, conser-  
18 vator, or trustee of the plan, the sponsor, or prop-  
19 erty of the plan or sponsor. Pending such adjudica-  
20 tion and upon the appointment by it of the Sec-  
21 retary as trustee, the court may stay any proceeding  
22 to enforce a lien against property of the plan or the  
23 sponsor or any other suit against the plan or the  
24 sponsor.

1           “(2) VENUE.—An action under this section  
 2           may be brought in the judicial district where the  
 3           sponsor or the plan administrator resides or does  
 4           business or where any asset of the plan is situated.  
 5           A district court in which such action is brought may  
 6           issue process with respect to such action in any  
 7           other judicial district.

8           “(g) PERSONNEL.—In accordance with regulations  
 9           which shall be prescribed by the Secretary through nego-  
 10          tiated rulemaking, the Secretary shall appoint, retain, and  
 11          compensate accountants, actuaries, and other professional  
 12          service personnel as may be necessary in connection with  
 13          the Secretary’s service as trustee under this section.

14   **“SEC. 811. STATE ASSESSMENT AUTHORITY.**

15          “(a) IN GENERAL.—Notwithstanding section 514, a  
 16          State may impose by law a contribution tax on an associa-  
 17          tion health plan described in section 806(a)(2), if the plan  
 18          commenced operations in such State after the date of the  
 19          enactment of the Small Business Access and Choice for  
 20          Entrepreneurs Act of 2003.

21          “(b) CONTRIBUTION TAX.—For purposes of this sec-  
 22          tion, the term ‘contribution tax’ imposed by a State on  
 23          an association health plan means any tax imposed by such  
 24          State if—



1           “(1) such tax is computed by applying a rate to  
2           the amount of premiums or contributions, with re-  
3           spect to individuals covered under the plan who are  
4           residents of such State, which are received by the  
5           plan from participating employers located in such  
6           State or from such individuals;

7           “(2) the rate of such tax does not exceed the  
8           rate of any tax imposed by such State on premiums  
9           or contributions received by insurers or health main-  
10          tenance organizations for health insurance coverage  
11          offered in such State in connection with a group  
12          health plan;

13          “(3) such tax is otherwise nondiscriminatory;  
14          and

15          “(4) the amount of any such tax assessed on  
16          the plan is reduced by the amount of any tax or as-  
17          sessment otherwise imposed by the State on pre-  
18          miums, contributions, or both received by insurers or  
19          health maintenance organizations for health insur-  
20          ance coverage, aggregate excess/stop loss insurance  
21          (as defined in section 806(g)(1)), specific excess/  
22          stop loss insurance (as defined in section 806(g)(2)),  
23          other insurance related to the provision of medical  
24          care under the plan, or any combination thereof pro-

1       vided by such insurers or health maintenance organi-  
2       zations in such State in connection with such plan.

3       **“SEC. 812. SPECIAL RULES FOR CHURCH PLANS.**

4       “(a) ELECTION FOR CHURCH PLANS.—Notwith-  
5       standing section 4(b)(2), if a church, a convention or asso-  
6       ciation of churches, or an organization described in section  
7       3(33)(C)(i) maintains a church plan which is a group  
8       health plan (as defined in section 733(a)(1)), and such  
9       church, convention, association, or organization makes an  
10      election with respect to such plan under this subsection  
11      (in such form and manner as the Secretary may by regula-  
12      tion prescribe), then the provisions of this section shall  
13      apply to such plan, with respect to benefits provided under  
14      such plan consisting of medical care, as if section 4(b)(2)  
15      did not contain an exclusion for church plans. Nothing in  
16      this subsection shall be construed to render any other sec-  
17      tion of this title applicable to church plans, except to the  
18      extent that such other section is incorporated by reference  
19      in this section.

20      “(b) EFFECT OF ELECTION.—

21              “(1) PREEMPTION OF STATE INSURANCE LAWS  
22      REGULATING COVERED CHURCH PLANS.—Subject to  
23      paragraphs (2) and (3), this section shall supersede  
24      any and all State laws which regulate insurance in-  
25      sofar as they may now or hereafter regulate church

1 plans to which this section applies or trusts estab-  
2 lished under such church plans.

3 “(2) GENERAL STATE INSURANCE REGULATION  
4 UNAFFECTED.—

5 “(A) IN GENERAL.—Except as provided in  
6 subparagraph (B) and paragraph (3), nothing  
7 in this section shall be construed to exempt or  
8 relieve any person from any provision of State  
9 law which regulates insurance.

10 “(B) CHURCH PLANS NOT TO BE DEEMED  
11 INSURANCE COMPANIES OR INSURERS.—Neither  
12 a church plan to which this section applies, nor  
13 any trust established under such a church plan,  
14 shall be deemed to be an insurance company or  
15 other insurer or to be engaged in the business  
16 of insurance for purposes of any State law pur-  
17 porting to regulate insurance companies or in-  
18 surance contracts.

19 “(3) PREEMPTION OF CERTAIN STATE LAWS  
20 RELATING TO PREMIUM RATE REGULATION AND  
21 BENEFIT MANDATES.—The provisions of subsections  
22 (a)(2)(B) and (b) of section 805 shall apply with re-  
23 spect to a church plan to which this section applies  
24 in the same manner and to the same extent as such

1 provisions apply with respect to association health  
2 plans.

3 “(4) DEFINITIONS.—For purposes of this sub-  
4 section—

5 “(A) STATE LAW.—The term ‘State law’  
6 includes all laws, decisions, rules, regulations,  
7 or other State action having the effect of law,  
8 of any State. A law of the United States appli-  
9 cable only to the District of Columbia shall be  
10 treated as a State law rather than a law of the  
11 United States.

12 “(B) STATE.—The term ‘State’ includes a  
13 State, any political subdivision thereof, or any  
14 agency or instrumentality of either, which pur-  
15 ports to regulate, directly or indirectly, the  
16 terms and conditions of church plans covered by  
17 this section.

18 “(c) REQUIREMENTS FOR COVERED CHURCH  
19 PLANS.—

20 “(1) FIDUCIARY RULES AND EXCLUSIVE PUR-  
21 POSE.—A fiduciary shall discharge his duties with  
22 respect to a church plan to which this section ap-  
23 plies—

24 “(A) for the exclusive purpose of:

1 “(i) providing benefits to participants  
2 and their beneficiaries; and

3 “(ii) defraying reasonable expenses of  
4 administering the plan;

5 “(B) with the care, skill, prudence and dili-  
6 gence under the circumstances then prevailing  
7 that a prudent man acting in a like capacity  
8 and familiar with such matters would use in the  
9 conduct of an enterprise of a like character and  
10 with like aims; and

11 “(C) in accordance with the documents  
12 and instruments governing the plan.

13 The requirements of this paragraph shall not be  
14 treated as not satisfied solely because the plan as-  
15 sets are commingled with other church assets, to the  
16 extent that such plan assets are separately ac-  
17 counted for.

18 “(2) CLAIMS PROCEDURE.—In accordance with  
19 regulations of the Secretary, every church plan to  
20 which this section applies shall—

21 “(A) provide adequate notice in writing to  
22 any participant or beneficiary whose claim for  
23 benefits under the plan has been denied, setting  
24 forth the specific reasons for such denial, writ-

1           ten in a manner calculated to be understood by  
2           the participant;

3           “(B) afford a reasonable opportunity to  
4           any participant whose claim for benefits has  
5           been denied for a full and fair review by the ap-  
6           propriate fiduciary of the decision denying the  
7           claim; and

8           “(C) provide a written statement to each  
9           participant describing the procedures estab-  
10          lished pursuant to this paragraph.

11          “(3) ANNUAL STATEMENTS.—In accordance  
12          with regulations of the Secretary, every church plan  
13          to which this section applies shall file with the Sec-  
14          retary an annual statement—

15               “(A) stating the names and addresses of  
16               the plan and of the church, convention, or asso-  
17               ciation maintaining the plan (and its principal  
18               place of business);

19               “(B) certifying that it is a church plan to  
20               which this section applies and that it complies  
21               with the requirements of paragraphs (1) and  
22               (2);

23               “(C) identifying the States in which par-  
24               ticipants and beneficiaries under the plan are or

1           likely will be located during the 1-year period  
2           covered by the statement; and

3           “(D) containing a copy of a statement of  
4           actuarial opinion signed by a qualified actuary  
5           that the plan maintains capital, reserves, insur-  
6           ance, other financial arrangements, or any com-  
7           bination thereof adequate to enable the plan to  
8           fully meet all of its financial obligations on a  
9           timely basis.

10          “(4) DISCLOSURE.—At the time that the an-  
11         nual statement is filed by a church plan with the  
12         Secretary pursuant to paragraph (3), a copy of such  
13         statement shall be made available by the Secretary  
14         to the State insurance commissioner (or similar offi-  
15         cial) of any State. The name of each church plan  
16         and sponsoring organization filing an annual state-  
17         ment in compliance with paragraph (3) shall be pub-  
18         lished annually in the Federal Register.

19          “(d) ENFORCEMENT.—The Secretary may enforce  
20         the provisions of this section in a manner consistent with  
21         section 502, to the extent applicable with respect to ac-  
22         tions under section 502(a)(5), and with section 3(33)(D),  
23         except that, other than for the purpose of seeking a tem-  
24         porary restraining order, a civil action may be brought  
25         with respect to the plan’s failure to meet any requirement

1 of this section only if the plan fails to correct its failure  
 2 within the correction period described in section 3(33)(D).  
 3 The other provisions of part 5 (except sections 501(a),  
 4 503, 512, 514, and 515) shall apply with respect to the  
 5 enforcement and administration of this section.

6 “(e) DEFINITIONS AND OTHER RULES.—For pur-  
 7 poses of this section—

8 “(1) IN GENERAL.—Except as otherwise pro-  
 9 vided in this section, any term used in this section  
 10 which is defined in any provision of this title shall  
 11 have the definition provided such term by such pro-  
 12 vision.

13 “(2) SEMINARY STUDENTS.—Seminary students  
 14 who are enrolled in an institution of higher learning  
 15 described in section 3(33)(C)(iv) and who are treat-  
 16 ed as participants under the terms of a church plan  
 17 to which this section applies shall be deemed to be  
 18 employees as defined in section 3(6) if the number  
 19 of such students constitutes an insignificant portion  
 20 of the total number of individuals who are treated  
 21 as participants under the terms of the plan.

22 **“SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.**

23 “(a) DEFINITIONS.—For purposes of this part—

24 “(1) GROUP HEALTH PLAN.—The term ‘group  
 25 health plan’ has the meaning provided in section



1       733(a)(1) (after applying subsection (b) of this sec-  
2       tion).

3           “(2) MEDICAL CARE.—The term ‘medical care’  
4       has the meaning provided in section 733(a)(2).

5           “(3) HEALTH INSURANCE COVERAGE.—The  
6       term ‘health insurance coverage’ has the meaning  
7       provided in section 733(b)(1).

8           “(4) HEALTH INSURANCE ISSUER.—The term  
9       ‘health insurance issuer’ has the meaning provided  
10      in section 733(b)(2).

11          “(5) APPLICABLE AUTHORITY.—

12               “(A) IN GENERAL.—Except as provided in  
13       subparagraph (B), the term ‘applicable author-  
14       ity’ means, in connection with an association  
15       health plan—

16                   “(i) the State recognized pursuant to  
17       subsection (c) of section 506 as the State  
18       to which authority has been delegated in  
19       connection with such plan; or

20                   “(ii) if there is no State referred to in  
21       clause (i), the Secretary.

22          “(B) EXCEPTIONS.—

23               “(i) JOINT AUTHORITIES.—Where  
24       such term appears in section 808(3), sec-  
25       tion 807(e) (in the first instance), section

1           809(a) (in the second instance), section  
2           809(a) (in the fourth instance), and sec-  
3           tion 809(b)(1), such term means, in con-  
4           nection with an association health plan, the  
5           Secretary and the State referred to in sub-  
6           paragraph (A)(i) (if any) in connection  
7           with such plan.

8           “(ii) REGULATORY AUTHORITIES.—  
9           Where such term appears in section 802(a)  
10          (in the first instance), section 802(d), sec-  
11          tion 802(e), section 803(d), section  
12          805(a)(5), section 806(a)(2), section  
13          806(b), section 806(c), section 806(d),  
14          paragraphs (1)(A) and (2)(A) of section  
15          806(g), section 806(h), section 806(i), sec-  
16          tion 806(j), section 807(a) (in the second  
17          instance), section 807(b), section 807(d),  
18          section 807(e) (in the second instance),  
19          section 808 (in the matter after paragraph  
20          (3)), and section 809(a) (in the third in-  
21          stance), such term means, in connection  
22          with an association health plan, the Sec-  
23          retary.

1           “(6) HEALTH STATUS-RELATED FACTOR.—The  
2           term ‘health status-related factor’ has the meaning  
3           provided in section 733(d)(2).

4           “(7) INDIVIDUAL MARKET.—

5                 “(A) IN GENERAL.—The term ‘individual  
6                 market’ means the market for health insurance  
7                 coverage offered to individuals other than in  
8                 connection with a group health plan.

9                 “(B) TREATMENT OF VERY SMALL  
10                GROUPS.—

11                         “(i) IN GENERAL.—Subject to clause  
12                         (ii), such term includes coverage offered in  
13                         connection with a group health plan that  
14                         has fewer than 2 participants as current  
15                         employees or participants described in sec-  
16                         tion 732(d)(3) on the first day of the plan  
17                         year.

18                         “(ii) STATE EXCEPTION.—Clause (i)  
19                         shall not apply in the case of health insur-  
20                         ance coverage offered in a State if such  
21                         State regulates the coverage described in  
22                         such clause in the same manner and to the  
23                         same extent as coverage in the small group  
24                         market (as defined in section 2791(e)(5) of

1                   the Public Health Service Act) is regulated  
2                   by such State.

3                   “(8) PARTICIPATING EMPLOYER.—The term  
4                   ‘participating employer’ means, in connection with  
5                   an association health plan, any employer, if any indi-  
6                   vidual who is an employee of such employer, a part-  
7                   ner in such employer, or a self-employed individual  
8                   who is such employer (or any dependent, as defined  
9                   under the terms of the plan, of such individual) is  
10                  or was covered under such plan in connection with  
11                  the status of such individual as such an employee,  
12                  partner, or self-employed individual in relation to the  
13                  plan.

14                  “(9) APPLICABLE STATE AUTHORITY.—The  
15                  term ‘applicable State authority’ means, with respect  
16                  to a health insurance issuer in a State, the State in-  
17                  surance commissioner or official or officials des-  
18                  ignated by the State to enforce the requirements of  
19                  title XXVII of the Public Health Service Act for the  
20                  State involved with respect to such issuer.

21                  “(10) QUALIFIED ACTUARY.—The term ‘quali-  
22                  fied actuary’ means an individual who is a member  
23                  of the American Academy of Actuaries or meets  
24                  such reasonable standards and qualifications as the

1 Secretary may provide by regulation through nego-  
2 tiated rulemaking.

3 “(11) AFFILIATED MEMBER.—The term ‘affili-  
4 ated member’ means, in connection with a sponsor—

5 “(A) a person who is otherwise eligible to  
6 be a member of the sponsor but who elects an  
7 affiliated status with the sponsor,

8 “(B) in the case of a sponsor with mem-  
9 bers which consist of associations, a person who  
10 is a member of any such association and elects  
11 an affiliated status with the sponsor, or

12 “(C) in the case of an association health  
13 plan in existence on the date of the enactment  
14 of the Small Business Access and Choice for  
15 Entrepreneurs Act of 2003, a person eligible to  
16 be a member of the sponsor or one of its mem-  
17 ber associations.

18 “(12) LARGE EMPLOYER.—The term ‘large em-  
19 ployer’ means, in connection with a group health  
20 plan with respect to a plan year, an employer who  
21 employed an average of at least 51 employees on  
22 business days during the preceding calendar year  
23 and who employs at least 2 employees on the first  
24 day of the plan year.

1           “(13) SMALL EMPLOYER.—The term ‘small em-  
2       ployer’ means, in connection with a group health  
3       plan with respect to a plan year, an employer who  
4       is not a large employer.

5       “(b) RULES OF CONSTRUCTION.—

6           “(1) EMPLOYERS AND EMPLOYEES.—For pur-  
7       poses of determining whether a plan, fund, or pro-  
8       gram is an employee welfare benefit plan which is an  
9       association health plan, and for purposes of applying  
10      this title in connection with such plan, fund, or pro-  
11      gram so determined to be such an employee welfare  
12      benefit plan—

13           “(A) in the case of a partnership, the term  
14       ‘employer’ (as defined in section (3)(5)) in-  
15       cludes the partnership in relation to the part-  
16       ners, and the term ‘employee’ (as defined in  
17       section (3)(6)) includes any partner in relation  
18       to the partnership; and

19           “(B) in the case of a self-employed indi-  
20       vidual, the term ‘employer’ (as defined in sec-  
21       tion 3(5)) and the term ‘employee’ (as defined  
22       in section 3(6)) shall include such individual.

23       “(2) PLANS, FUNDS, AND PROGRAMS TREATED  
24       AS EMPLOYEE WELFARE BENEFIT PLANS.—In the  
25       case of any plan, fund, or program which was estab-

1       lished or is maintained for the purpose of providing  
2       medical care (through the purchase of insurance or  
3       otherwise) for employees (or their dependents) cov-  
4       ered thereunder and which demonstrates to the Sec-  
5       retary that all requirements for certification under  
6       this part would be met with respect to such plan,  
7       fund, or program if such plan, fund, or program  
8       were a group health plan, such plan, fund, or pro-  
9       gram shall be treated for purposes of this title as an  
10      employee welfare benefit plan on and after the date  
11      of such demonstration.”.

12      (b) CONFORMING AMENDMENTS TO PREEMPTION  
13 RULES.—

14           (1) Section 514(b)(6) of such Act (29 U.S.C.  
15      1144(b)(6)) is amended by adding at the end the  
16      following new subparagraph:

17      “(E) The preceding subparagraphs of this paragraph  
18      do not apply with respect to any State law in the case  
19      of an association health plan which is certified under part  
20      8.”.

21           (2) Section 514 of such Act (29 U.S.C. 1144)  
22      is amended—

23           (A) in subsection (b)(4), by striking “Sub-  
24      section (a)” and inserting “Subsections (a) and  
25      (d)”;

1 (B) in subsection (b)(5), by striking “sub-  
2 section (a)” in subparagraph (A) and inserting  
3 “subsection (a) of this section and subsections  
4 (a)(2)(B) and (b) of section 805”, and by strik-  
5 ing “subsection (a)” in subparagraph (B) and  
6 inserting “subsection (a) of this section or sub-  
7 section (a)(2)(B) or (b) of section 805”;

8 (C) by redesignating subsection (d) as sub-  
9 section (e); and

10 (D) by inserting after subsection (c) the  
11 following new subsection:

12 “(d)(1) Except as provided in subsection (b)(4), the  
13 provisions of this title shall supersede any and all State  
14 laws insofar as they may now or hereafter preclude, or  
15 have the effect of precluding, a health insurance issuer  
16 from offering health insurance coverage in connection with  
17 an association health plan which is certified under part  
18 8.

19 “(2) Except as provided in paragraphs (4) and (5)  
20 of subsection (b) of this section—

21 “(A) In any case in which health insurance cov-  
22 erage of any policy type is offered under an associa-  
23 tion health plan certified under part 8 to a partici-  
24 pating employer operating in such State, the provi-  
25 sions of this title shall supersede any and all laws



1 of such State insofar as they may preclude a health  
2 insurance issuer from offering health insurance cov-  
3 erage of the same policy type to other employers op-  
4 erating in the State which are eligible for coverage  
5 under such association health plan, whether or not  
6 such other employers are participating employers in  
7 such plan.

8 “(B) In any case in which health insurance cov-  
9 erage of any policy type is offered under an associa-  
10 tion health plan in a State and the filing, with the  
11 applicable State authority, of the policy form in con-  
12 nection with such policy type is approved by such  
13 State authority, the provisions of this title shall su-  
14 persede any and all laws of any other State in which  
15 health insurance coverage of such type is offered, in-  
16 sofar as they may preclude, upon the filing in the  
17 same form and manner of such policy form with the  
18 applicable State authority in such other State, the  
19 approval of the filing in such other State.

20 “(3) For additional provisions relating to association  
21 health plans, see subsections (a)(2)(B) and (b) of section  
22 805.

23 “(4) For purposes of this subsection, the term ‘asso-  
24 ciation health plan’ has the meaning provided in section  
25 801(a), and the terms ‘health insurance coverage’, ‘par-

1 participating employer’, and ‘health insurance issuer’ have  
 2 the meanings provided such terms in section 811, respec-  
 3 tively.”.

4 (3) Section 514(b)(6)(A) of such Act (29  
 5 U.S.C. 1144(b)(6)(A)) is amended—

6 (A) in clause (i)(II), by striking “and” at  
 7 the end;

8 (B) in clause (ii), by inserting “and which  
 9 does not provide medical care (within the mean-  
 10 ing of section 733(a)(2)),” after “arrange-  
 11 ment,” and by striking “title.” and inserting  
 12 “title, and”; and

13 (C) by adding at the end the following new  
 14 clause:

15 “(iii) subject to subparagraph (E), in the case  
 16 of any other employee welfare benefit plan which is  
 17 a multiple employer welfare arrangement and which  
 18 provides medical care (within the meaning of section  
 19 733(a)(2)), any law of any State which regulates in-  
 20 surance may apply.”.

21 (4) Section 514(e) of such Act (as redesignated  
 22 by paragraph (2)(C)) is amended—

23 (A) by striking “Nothing” and inserting  
 24 “(1) Except as provided in paragraph (2), noth-  
 25 ing”; and

1 (B) by adding at the end the following new  
2 paragraph:

3 “(2) Nothing in any other provision of law enacted  
4 on or after the date of the enactment of the Small Busi-  
5 ness Access and Choice for Entrepreneurs Act of 2003  
6 shall be construed to alter, amend, modify, invalidate, im-  
7 pair, or supersede any provision of this title, except by  
8 specific cross-reference to the affected section.”.

9 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act  
10 (29 U.S.C. 102(16)(B)) is amended by adding at the end  
11 the following new sentence: “Such term also includes a  
12 person serving as the sponsor of an association health plan  
13 under part 8.”.

14 (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-  
15 LATED TO SELF-INSURED AND FULLY INSURED OPTIONS  
16 UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)  
17 of such Act (29 U.S.C. 102(b)) is amended by adding at  
18 the end the following: “An association health plan shall  
19 include in its summary plan description, in connection  
20 with each benefit option, a description of the form of sol-  
21 vency or guarantee fund protection secured pursuant to  
22 this Act or applicable State law, if any.”.

23 (e) SAVINGS CLAUSE.—Section 731(c) of such Act is  
24 amended by inserting “or part 8” after “this part”.

1       (f) REPORT TO THE CONGRESS REGARDING CERTIFI-  
 2 CATION OF SELF-INSURED ASSOCIATION HEALTH  
 3 PLANS.—Not later than January 1, 2008, the Secretary  
 4 of Labor shall report to the Committee on Education and  
 5 the Workforce of the House of Representatives and the  
 6 Committee on Health, Education, Labor, and Pensions of  
 7 the Senate the effect association health plans have had,  
 8 if any, on reducing the number of uninsured individuals.

9       (g) CLERICAL AMENDMENT.—The table of contents  
 10 in section 1 of the Employee Retirement Income Security  
 11 Act of 1974 is amended by inserting after the item relat-  
 12 ing to section 734 the following new items:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

- “Sec. 801. Association health plans.
- “Sec. 802. Certification of association health plans.
- “Sec. 803. Requirements relating to sponsors and boards of trustees.
- “Sec. 804. Participation and coverage requirements.
- “Sec. 805. Other requirements relating to plan documents, contribution rates,  
and benefit options.
- “Sec. 806. Maintenance of reserves and provisions for solvency for plans pro-  
viding health benefits in addition to health insurance coverage.
- “Sec. 807. Requirements for application and related requirements.
- “Sec. 808. Notice requirements for voluntary termination.
- “Sec. 809. Corrective actions and mandatory termination.
- “Sec. 810. Trusteeship by the Secretary of insolvent association health plans  
providing health benefits in addition to health insurance cov-  
erage.
- “Sec. 811. State assessment authority.
- “Sec. 812. Special rules for church plans.
- “Sec. 813. Definitions and rules of construction.”.

1 **SEC. 403. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
2 **PLOYER ARRANGEMENTS.**

3 Section 3(40)(B) of the Employee Retirement Income  
4 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-  
5 ed—

6 (1) in clause (i), by inserting “for any plan year  
7 of any such plan, or any fiscal year of any such  
8 other arrangement,” after “single employer”, and by  
9 inserting “during such year or at any time during  
10 the preceding 1-year period” after “control group”;

11 (2) in clause (iii)—

12 (A) by striking “common control shall not  
13 be based on an interest of less than 25 percent”  
14 and inserting “an interest of greater than 25  
15 percent may not be required as the minimum  
16 interest necessary for common control”; and

17 (B) by striking “similar to” and inserting  
18 “consistent and coextensive with”;

19 (3) by redesignating clauses (iv) and (v) as  
20 clauses (v) and (vi), respectively; and

21 (4) by inserting after clause (iii) the following  
22 new clause:

23 “(iv) in determining, after the application of  
24 clause (i), whether benefits are provided to employ-  
25 ees of two or more employers, the arrangement shall  
26 be treated as having only one participating employer

1 if, after the application of clause (i), the number of  
 2 individuals who are employees and former employees  
 3 of any one participating employer and who are cov-  
 4 ered under the arrangement is greater than 75 per-  
 5 cent of the aggregate number of all individuals who  
 6 are employees or former employees of participating  
 7 employers and who are covered under the arrange-  
 8 ment;”.

9 **SEC. 404. CLARIFICATION OF TREATMENT OF CERTAIN**  
 10 **COLLECTIVELY BARGAINED ARRANGE-**  
 11 **MENTS.**

12 (a) IN GENERAL.—Section 3(40)(A)(i) of the Em-  
 13 ployee Retirement Income Security Act of 1974 (29  
 14 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

15 “(i)(I) under or pursuant to one or more collec-  
 16 tive bargaining agreements which are reached pursu-  
 17 ant to collective bargaining described in section 8(d)  
 18 of the National Labor Relations Act (29 U.S.C.  
 19 158(d)) or paragraph Fourth of section 2 of the  
 20 Railway Labor Act (45 U.S.C. 152, paragraph  
 21 Fourth) or which are reached pursuant to labor-  
 22 management negotiations under similar provisions of  
 23 State public employee relations laws, and (II) in ac-  
 24 cordance with subparagraphs (C), (D), and (E);”.

1 (b) LIMITATIONS.—Section 3(40) of such Act (29  
2 U.S.C. 1002(40)) is amended by adding at the end the  
3 following new subparagraphs:

4 “(C) For purposes of subparagraph (A)(i)(II), a plan  
5 or other arrangement shall be treated as established or  
6 maintained in accordance with this subparagraph only if  
7 the following requirements are met:

8 “(i) The plan or other arrangement, and the  
9 employee organization or any other entity sponsoring  
10 the plan or other arrangement, do not—

11 “(I) utilize the services of any licensed in-  
12 surance agent or broker for soliciting or enroll-  
13 ing employers or individuals as participating  
14 employers or covered individuals under the plan  
15 or other arrangement; or

16 “(II) pay any type of compensation to a  
17 person, other than a full time employee of the  
18 employee organization (or a member of the or-  
19 ganization to the extent provided in regulations  
20 prescribed by the Secretary through negotiated  
21 rulemaking), that is related either to the volume  
22 or number of employers or individuals solicited  
23 or enrolled as participating employers or cov-  
24 ered individuals under the plan or other ar-  
25 rangement, or to the dollar amount or size of

1 the contributions made by participating employ-  
2 ers or covered individuals to the plan or other  
3 arrangement;

4 except to the extent that the services used by the  
5 plan, arrangement, organization, or other entity con-  
6 sist solely of preparation of documents necessary for  
7 compliance with the reporting and disclosure re-  
8 quirements of part 1 or administrative, investment,  
9 or consulting services unrelated to solicitation or en-  
10 rollment of covered individuals.

11 “(ii) As of the end of the preceding plan year,  
12 the number of covered individuals under the plan or  
13 other arrangement who are neither—

14 “(I) employed within a bargaining unit  
15 covered by any of the collective bargaining  
16 agreements with a participating employer (nor  
17 covered on the basis of an individual’s employ-  
18 ment in such a bargaining unit); nor

19 “(II) present employees (or former employ-  
20 ees who were covered while employed) of the  
21 sponsoring employee organization, of an em-  
22 ployer who is or was a party to any of the col-  
23 lective bargaining agreements, or of the plan or  
24 other arrangement or a related plan or arrange-



1           ment (nor covered on the basis of such present  
2           or former employment);  
3       does not exceed 15 percent of the total number of  
4       individuals who are covered under the plan or ar-  
5       rangement and who are present or former employees  
6       who are or were covered under the plan or arrange-  
7       ment pursuant to a collective bargaining agreement  
8       with a participating employer. The requirements of  
9       the preceding provisions of this clause shall be treat-  
10      ed as satisfied if, as of the end of the preceding plan  
11      year, such covered individuals are comprised solely  
12      of individuals who were covered individuals under  
13      the plan or other arrangement as of the date of the  
14      enactment of the Small Business Access and Choice  
15      for Entrepreneurs Act of 2003 and, as of the end of  
16      the preceding plan year, the number of such covered  
17      individuals does not exceed 25 percent of the total  
18      number of present and former employees enrolled  
19      under the plan or other arrangement.

20           “(iii) The employee organization or other entity  
21      sponsoring the plan or other arrangement certifies  
22      to the Secretary each year, in a form and manner  
23      which shall be prescribed by the Secretary through  
24      negotiated rulemaking that the plan or other ar-

1       rangement meets the requirements of clauses (i) and  
2       (ii).

3       “(D) For purposes of subparagraph (A)(i)(II), a plan  
4 or arrangement shall be treated as established or main-  
5 tained in accordance with this subparagraph only if—

6               “(i) all of the benefits provided under the plan  
7 or arrangement consist of health insurance coverage;  
8 or

9               “(ii)(I) the plan or arrangement is a multiem-  
10 ployer plan; and

11               “(II) the requirements of clause (B) of the pro-  
12 viso to clause (5) of section 302(c) of the Labor  
13 Management Relations Act, 1947 (29 U.S.C.  
14 186(c)) are met with respect to such plan or other  
15 arrangement.

16       “(E) For purposes of subparagraph (A)(i)(II), a plan  
17 or arrangement shall be treated as established or main-  
18 tained in accordance with this subparagraph only if—

19               “(i) the plan or arrangement is in effect as of  
20 the date of the enactment of the Small Business Ac-  
21 cess and Choice for Entrepreneurs Act of 2003; or

22               “(ii) the employee organization or other entity  
23 sponsoring the plan or arrangement—

24                       “(I) has been in existence for at least 3  
25 years; or

1           “(II) demonstrates to the satisfaction of  
2           the Secretary that the requirements of subpara-  
3           graphs (C) and (D) are met with respect to the  
4           plan or other arrangement.”.

5           (c) CONFORMING AMENDMENTS TO DEFINITIONS OF  
6 PARTICIPANT AND BENEFICIARY.—Section 3(7) of such  
7 Act (29 U.S.C. 1002(7)) is amended by adding at the end  
8 the following new sentence: “Such term includes an indi-  
9 vidual who is a covered individual described in paragraph  
10 (40)(C)(ii).”.

11 **SEC. 405. ENFORCEMENT PROVISIONS.**

12           (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL  
13 MISREPRESENTATIONS.—Section 501 of the Employee  
14 Retirement Income Security Act of 1974 (29 U.S.C. 1131)  
15 is amended—

16           (1) by inserting “(a)” after “SEC. 501.”; and  
17           (2) by adding at the end the following new sub-  
18           section:

19           “(b) Any person who willfully falsely represents, to  
20 any employee, any employee’s beneficiary, any employer,  
21 the Secretary, or any State, a plan or other arrangement  
22 established or maintained for the purpose of offering or  
23 providing any benefit described in section 3(1) to employ-  
24 ees or their beneficiaries as—

1           “(1) being an association health plan which has  
2       been certified under part 8;

3           “(2) having been established or maintained  
4       under or pursuant to one or more collective bar-  
5       gaining agreements which are reached pursuant to  
6       collective bargaining described in section 8(d) of the  
7       National Labor Relations Act (29 U.S.C. 158(d)) or  
8       paragraph Fourth of section 2 of the Railway Labor  
9       Act (45 U.S.C. 152, paragraph Fourth) or which are  
10      reached pursuant to labor-management negotiations  
11      under similar provisions of State public employee re-  
12      lations laws; or

13          “(3) being a plan or arrangement with respect  
14      to which the requirements of subparagraph (C), (D),  
15      or (E) of section 3(40) are met;

16 shall, upon conviction, be imprisoned not more than 5  
17 years, be fined under title 18, United States Code, or  
18 both.”.

19       (b) CEASE ACTIVITIES ORDERS.—Section 502 of  
20 such Act (29 U.S.C. 1132) is amended by adding at the  
21 end the following new subsection:

22       “(n)(1) Subject to paragraph (2), upon application  
23 by the Secretary showing the operation, promotion, or  
24 marketing of an association health plan (or similar ar-

1 rangement providing benefits consisting of medical care  
2 (as defined in section 733(a)(2))) that—

3 “(A) is not certified under part 8, is subject  
4 under section 514(b)(6) to the insurance laws of any  
5 State in which the plan or arrangement offers or  
6 provides benefits, and is not licensed, registered, or  
7 otherwise approved under the insurance laws of such  
8 State; or

9 “(B) is an association health plan certified  
10 under part 8 and is not operating in accordance with  
11 the requirements under part 8 for such certification,  
12 a district court of the United States shall enter an order  
13 requiring that the plan or arrangement cease activities.

14 “(2) Paragraph (1) shall not apply in the case of an  
15 association health plan or other arrangement if the plan  
16 or arrangement shows that—

17 “(A) all benefits under it referred to in para-  
18 graph (1) consist of health insurance coverage; and

19 “(B) with respect to each State in which the  
20 plan or arrangement offers or provides benefits, the  
21 plan or arrangement is operating in accordance with  
22 applicable State laws that are not superseded under  
23 section 514.

24 “(3) The court may grant such additional equitable  
25 relief, including any relief available under this title, as it

1 deems necessary to protect the interests of the public and  
 2 of persons having claims for benefits against the plan.”.

3 (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—

4 Section 503 of such Act (29 U.S.C. 1133) is amended—

5 (1) by inserting “(a) IN GENERAL.—” after  
 6 “SEC. 503.”; and

7 (2) by adding at the end the following new sub-  
 8 section:

9 “(b) ASSOCIATION HEALTH PLANS.—The terms of  
 10 each association health plan which is or has been certified  
 11 under part 8 shall require the board of trustees or the  
 12 named fiduciary (as applicable) to ensure that the require-  
 13 ments of this section are met in connection with claims  
 14 filed under the plan.”.

15 **SEC. 406. COOPERATION BETWEEN FEDERAL AND STATE**  
 16 **AUTHORITIES.**

17 Section 506 of the Employee Retirement Income Se-  
 18 curity Act of 1974 (29 U.S.C. 1136) is amended by adding  
 19 at the end the following new subsection:

20 “(d) RESPONSIBILITY OF STATES WITH RESPECT TO  
 21 ASSOCIATION HEALTH PLANS.—

22 “(1) AGREEMENTS WITH STATES.—A State  
 23 may enter into an agreement with the Secretary for  
 24 delegation to the State of some or all of—

1           “(A) the Secretary’s authority under sec-  
2           tions 502 and 504 to enforce the requirements  
3           for certification under part 8;

4           “(B) the Secretary’s authority to certify  
5           association health plans under part 8 in accord-  
6           ance with regulations of the Secretary applica-  
7           ble to certification under part 8; or

8           “(C) any combination of the Secretary’s  
9           authority authorized to be delegated under sub-  
10          paragraphs (A) and (B).

11          “(2) DELEGATIONS.—Any department, agency,  
12          or instrumentality of a State to which authority is  
13          delegated pursuant to an agreement entered into  
14          under this paragraph may, if authorized under State  
15          law and to the extent consistent with such agree-  
16          ment, exercise the powers of the Secretary under  
17          this title which relate to such authority.

18          “(3) RECOGNITION OF PRIMARY DOMICILE  
19          STATE.—In entering into any agreement with a  
20          State under subparagraph (A), the Secretary shall  
21          ensure that, as a result of such agreement and all  
22          other agreements entered into under subparagraph  
23          (A), only one State will be recognized, with respect  
24          to any particular association health plan, as the  
25          State to which all authority has been delegated pur-

1        suant to such agreements in connection with such  
 2        plan. In carrying out this paragraph, the Secretary  
 3        shall take into account the places of residence of the  
 4        participants and beneficiaries under the plan and the  
 5        State in which the trust is maintained.”.

6    **SEC. 407. EFFECTIVE DATE AND TRANSITIONAL AND**  
 7                                    **OTHER RULES.**

8        (a) **EFFECTIVE DATE.**—The amendments made by  
 9        sections 101, 104, and 105 shall take effect on January  
 10    1, 2005. The amendments made by sections 102 and 103  
 11    shall take effect on the date of the enactment of this Act.  
 12    The Secretary of Labor shall first issue all regulations  
 13    necessary to carry out the amendments made by this sub-  
 14    title before January 1, 2005. Such regulations shall be  
 15    issued through negotiated rulemaking.

16        (b) **EXCEPTION.**—Section 801(a)(2) of the Employee  
 17    Retirement Income Security Act of 1974 (added by section  
 18    101) does not apply in connection with an association  
 19    health plan (certified under part 8 of subtitle B of title  
 20    I of such Act) existing on the date of the enactment of  
 21    this Act, if no benefits provided thereunder as of the date  
 22    of the enactment of this Act consist of health insurance  
 23    coverage (as defined in section 733(b)(1) of such Act).

24        (c) **TREATMENT OF CERTAIN EXISTING HEALTH**  
 25    **BENEFITS PROGRAMS.**—



1           (1) IN GENERAL.—In any case in which, as of  
2           the date of the enactment of this Act, an arrange-  
3           ment is maintained in a State for the purpose of  
4           providing benefits consisting of medical care for the  
5           employees and beneficiaries of its participating em-  
6           ployers, at least 200 participating employers make  
7           contributions to such arrangement, such arrange-  
8           ment has been in existence for at least 10 years, and  
9           such arrangement is licensed under the laws of one  
10          or more States to provide such benefits to its par-  
11          ticipating employers, upon the filing with the appli-  
12          cable authority (as defined in section 813(a)(5) of  
13          the Employee Retirement Income Security Act of  
14          1974 (as amended by this Act)) by the arrangement  
15          of an application for certification of the arrangement  
16          under part 8 of subtitle B of title I of such Act—

17                 (A) such arrangement shall be deemed to  
18                 be a group health plan for purposes of title I  
19                 of such Act;

20                 (B) the requirements of sections 801(a)(1)  
21                 and 803(a)(1) of the Employee Retirement In-  
22                 come Security Act of 1974 shall be deemed met  
23                 with respect to such arrangement;

24                 (C) the requirements of section 803(b) of  
25                 such Act shall be deemed met, if the arrange-

1           ment is operated by a board of directors  
2           which—

3                   (i) is elected by the participating em-  
4                   ployers, with each employer having one  
5                   vote; and

6                   (ii) has complete fiscal control over  
7                   the arrangement and which is responsible  
8                   for all operations of the arrangement;

9           (D) the requirements of section 804(a) of  
10          such Act shall be deemed met with respect to  
11          such arrangement; and

12          (E) the arrangement may be certified by  
13          any applicable authority with respect to its op-  
14          erations in any State only if it operates in such  
15          State on the date of certification.

16          The provisions of this subsection shall cease to apply  
17          with respect to any such arrangement at such time  
18          after the date of the enactment of this Act as the  
19          applicable requirements of this subsection are not  
20          met with respect to such arrangement.

21          (2) DEFINITIONS.—For purposes of this sub-  
22          section, the terms “group health plan”, “medical  
23          care”, and “participating employer” shall have the  
24          meanings provided in section 813 of the Employee  
25          Retirement Income Security Act of 1974, except

1       that the reference in paragraph (7) of such section  
 2       to an “association health plan” shall be deemed a  
 3       reference to an arrangement referred to in this sub-  
 4       section.

5   **TITLE V—IMPROVEMENT TO AC-**  
 6       **CESS       AND       CHOICE       OF**  
 7       **HEALTH CARE**

8   **SEC. 501. REFUNDABLE CREDIT FOR HEALTH INSURANCE**  
 9       **COSTS.**

10       (a) IN GENERAL.—Subpart C of part IV of sub-  
 11 chapter A of chapter 1 of the Internal Revenue Code of  
 12 1986 (relating to refundable credits) is amended by redes-  
 13 ignating section 36 as section 37 and by inserting after  
 14 section 35 the following new section:

15   **“SEC. 36. HEALTH INSURANCE COSTS.**

16       “(a) IN GENERAL.—In the case of an individual,  
 17 there shall be allowed as a credit against the tax imposed  
 18 by this subtitle an amount equal to the amount paid dur-  
 19 ing the taxable year for qualified health insurance for cov-  
 20 erage of the taxpayer, his spouse, and dependents.

21       “(b) LIMITATIONS.—

22               “(1) MAXIMUM CREDIT.—

23                       “(A) IN GENERAL.—The amount allowed  
 24                       as a credit under subsection (a) to the taxpayer  
 25                       for the taxable year shall not exceed the sum of

1 the monthly limitations for months during such  
2 taxable year.

3 “(B) MONTHLY LIMITATION.—The month-  
4 ly limitation for any month is the amount equal  
5 to  $\frac{1}{12}$  of the lesser of—

6 “(i) the product of \$1,000 multiplied  
7 by the number of individuals taken into ac-  
8 count under subsection (a) who are covered  
9 under qualified health insurance as of the  
10 first day of such month, or

11 “(ii) \$3,000.

12 “(2) EMPLOYER SUBSIDIZED COVERAGE.—Sub-  
13 section (a) shall not apply to amounts paid for cov-  
14 erage of any individual for any month for which  
15 such individual participates in any subsidized health  
16 plan maintained by any employer of the taxpayer or  
17 of the spouse of the taxpayer. The rule of the last  
18 sentence of section 162(l)(2)(B) shall apply for pur-  
19 poses of the preceding sentence.

20 “(c) QUALIFIED HEALTH INSURANCE.—For pur-  
21 poses of this section—

22 “(1) IN GENERAL.—The term ‘qualified health  
23 insurance’ means insurance which constitutes med-  
24 ical care if—

1           “(A) there is an annual deductible which is  
2           not more than the highest deductible permitted  
3           under—

4                   “(i) section 220(c)(2)(A)(i) in the  
5                   case of self-only coverage, or

6                   “(ii) section 220(c)(2)(A)(ii) in the  
7                   case of family coverage,

8           “(B) the annual out-of-pocket expenses re-  
9           quired to be paid (other than for premiums) for  
10          covered benefits does not exceed the amounts  
11          specified in section 220(c)(2)(A)(iii),

12          “(C) there is no exclusion from, or limita-  
13          tion on, coverage for any preexisting medical  
14          condition of any applicant who, on the date the  
15          application is made, has been continuously in-  
16          sured during the 1-year period ending on the  
17          date of the application under—

18                   “(i) qualified health insurance (deter-  
19                   mined without regard to this subpara-  
20                   graph), or

21                   “(ii) a program described in—

22                           “(I) title XVIII or XIX of the  
23                           Social Security Act,

24                           “(II) chapter 55 of title 10,  
25                           United States Code,

1 “(III) chapter 17 of title 38,  
2 United States Code,

3 “(IV) chapter 89 of title 5,  
4 United States Code, or

5 “(V) the Indian Health Care Im-  
6 provement Act, and

7 “(D) in the case of each applicant who has  
8 not been continuously so insured during the 1-  
9 year period ending on the date the application  
10 is made, the exclusion from, or limitation on,  
11 coverage for any preexisting medical condition  
12 does not extend beyond the period after such  
13 date equal to the lesser of—

14 “(i) the number of months imme-  
15 diately prior to such date during which the  
16 individual was not so insured since the ill-  
17 ness or condition in question was first di-  
18 agnosed, or

19 “(ii) 1 year.

20 “(2) EXCLUSION OF CERTAIN PLANS.—Such  
21 term does not include—

22 “(A) insurance if substantially all of its  
23 coverage is coverage described in section  
24 220(c)(1)(B),

1           “(B) insurance under a program described  
2           in paragraph (1)(C)(ii).

3           “(3) TRANSITION RULE FOR 2003.—In the case  
4           of applications made during 2003, the requirements  
5           of subparagraphs (C) and (D) of paragraph (1) are  
6           met only if the insurance does not exclude from cov-  
7           erage, or limit coverage for, any preexisting medical  
8           condition of any applicant.

9           “(d) SPECIAL RULES.—

10          “(1) COORDINATION WITH MEDICAL DEDUC-  
11          TION, ETC.—Any amount paid by a taxpayer for in-  
12          surance to which subsection (a) applies shall not be  
13          taken into account in computing the amount allow-  
14          able to the taxpayer as a credit under section 35 or  
15          as a deduction under section 162(l) or 213(a).

16          “(2) DENIAL OF CREDIT TO DEPENDENTS.—No  
17          credit shall be allowed under this section to any indi-  
18          vidual with respect to whom a deduction under sec-  
19          tion 151 is allowable to another taxpayer for a tax-  
20          able year beginning in the calendar year in which  
21          such individual’s taxable year begins.

22          “(3) MARRIED COUPLES MUST FILE JOINT RE-  
23          TURN.—

24          “(A) IN GENERAL.—If the taxpayer is  
25          married at the close of the taxable year, the

1 credit shall be allowed under subsection (a) only  
2 if the taxpayer and his spouse file a joint return  
3 for the taxable year.

4 “(B) MARITAL STATUS; CERTAIN MARRIED  
5 INDIVIDUALS LIVING APART.—Rules similar to  
6 the rules of paragraphs (3) and (4) of section  
7 21(e) shall apply for purposes of this para-  
8 graph.

9 “(4) VERIFICATION OF COVERAGE, ETC.—No  
10 credit shall be allowed under this section to any indi-  
11 vidual unless such individual’s coverage under quali-  
12 fied health insurance, and the amount paid for such  
13 coverage, are verified in such manner as the Sec-  
14 retary may prescribe.

15 “(5) COST-OF-LIVING ADJUSTMENT.—In the  
16 case of any taxable year beginning in a calendar  
17 year after 2003, each dollar amount contained in  
18 subsection (b)(1)(B) shall be increased by an  
19 amount equal to—

20 “(A) such dollar amount, multiplied by

21 “(B) the cost-of-living adjustment deter-  
22 mined under section 1(f)(3) for the calendar  
23 year in which the taxable year begins by sub-  
24 stituting ‘calendar year 2002’ for ‘calendar year  
25 1992’ in subparagraph (B) thereof.



1 Any increase determined under the preceding sen-  
2 tence shall be rounded to the nearest multiple of  
3 \$10.”.

4 (b) CONFORMING AMENDMENTS.—

5 (1) Paragraph (2) of section 1324(b) of title  
6 31, United States Code, is amended by inserting be-  
7 fore the period “or 36” after “section 35”.

8 (2) The table of sections for subpart C of part  
9 IV of subchapter A of chapter 1 of such Code is  
10 amended by inserting after the item relating to sec-  
11 tion 35 the following new item:

“Sec. 36. Health insurance costs.”.

12 (c) EFFECTIVE DATE.—The amendments made by  
13 this section shall apply to taxable years beginning after  
14 December 31, 2002.

15 **SEC. 502. EXCLUSION FOR EMPLOYER PAYMENTS MADE TO**  
16 **COMPENSATE EMPLOYEES WHO ELECT NOT**  
17 **TO PARTICIPATE IN EMPLOYER-SUBSIDIZED**  
18 **HEALTH PLANS.**

19 (a) IN GENERAL.—Part III of subchapter B of chap-  
20 ter 1 of the Internal Revenue Code of 1986 (relating to  
21 items specifically excluded from gross income) is amended  
22 by inserting after section 139 the following new section:

1 **“SEC. 139A. TREATMENT OF COMPENSATING PAYMENTS**  
2 **MADE FOR EMPLOYEES WHO ELECT NOT TO**  
3 **PARTICIPATE IN EMPLOYER-SUBSIDIZED**  
4 **HEALTH PLANS.**

5 “(a) IN GENERAL.—Gross income of an eligible em-  
6 ployee shall not include the amount of any compensating  
7 coverage payment made by an employer of such employee  
8 for such employee’s benefit.

9 “(b) ELIGIBLE EMPLOYEE.—For purposes of this  
10 section, the term ‘eligible employee’ means any employee  
11 who is eligible to participate in any subsidized health plan  
12 of an employer for any period and who elects not to par-  
13 ticipate in any subsidized health plan of such employer  
14 for such period.

15 “(c) COMPENSATING COVERAGE PAYMENT.—For  
16 purposes of this section, the term ‘compensating coverage  
17 payment’ means—

18 “(1) any payment made by the employer for  
19 qualified health insurance specified by the employee  
20 (for any period for which the employee is described  
21 in subsection (b)) which covers all of the individuals  
22 who, but for the election referred to in subsection  
23 (b), would be covered under the subsidized health  
24 plan of the employer, and

25 “(2) any payment made by the employer to any  
26 medical savings account of such employee or spouse

1       for a period for which the employee is covered by  
2       qualified health insurance.

3       “(d) QUALIFIED HEALTH INSURANCE.—For pur-  
4 poses of this section, the term ‘qualified health insurance’  
5 has the meaning given such term in section 36(c).

6       “(e) EMPLOYER PARTICIPATION.—

7               “(1) IN GENERAL.—This section shall apply to  
8 a compensating coverage payment made by an em-  
9 ployer for an employee’s benefit only if—

10               “(A) the employer, and all other employers  
11 which are members of any controlled group  
12 which includes such employer, agree to make  
13 such payments to all their eligible employees,

14               “(B) the amount of such payment is not  
15 less than the employer health plan contribution  
16 for such period with respect to the employee,  
17 and

18               “(C) the employer permits the election re-  
19 ferred to in subsection (b) to be made by em-  
20 ployees—

21               “(i) at the commencement of employ-  
22 ment with the employer, and

23               “(ii) during open enrollment periods  
24 (not less frequently than annually) of at  
25 least 30 days.

1           “(2) EXCEPTION FOR CERTAIN EMPLOYEES.—

2           Paragraph (1) shall not apply to—

3                   “(A) any employee who is covered under a  
4                   subsidized health plan of another employer of  
5                   such employee or of an employer of such em-  
6                   ployee’s spouse,

7                   “(B) any employee who normally works  
8                   less than 25 hours per week,

9                   “(C) any employee who normally works  
10                  during not more than 6 months during any  
11                  year,

12                  “(D) any employee who has not attained  
13                  age 21, and

14                  “(E) except to the extent provided in regu-  
15                  lations, any employee who is included in a unit  
16                  of employees covered by an agreement which  
17                  the Secretary of Labor finds to be a collective  
18                  bargaining agreement between employee rep-  
19                  resentatives and the employer.

20           “(3) CONTROLLED GROUPS.—Rules similar to  
21           the rules of subclauses (II) and (III) of paragraph  
22           (4)(D)(iii) shall apply for purposes of paragraph  
23           (1)(A).

24           “(4) EMPLOYER HEALTH PLAN CONTRIBU-  
25           TION.—For purposes of this section—

1           “(A) IN GENERAL.—The term ‘employer  
2 health plan contribution’ means the applicable  
3 premium for the employee reduced by the em-  
4 ployee’s share of such premium.

5           “(B) APPLICABLE PREMIUM.—Except as  
6 provided in subparagraph (D), the term ‘appli-  
7 cable premium’ means an amount which is not  
8 less than 98 percent of—

9               “(i) the applicable premium (as de-  
10 fined in section 4980B(f)(4)) for the em-  
11 ployee, or

12               “(ii) if an election under subpara-  
13 graph (D) is in effect with respect to an  
14 employee, the applicable premium deter-  
15 mined under subparagraph (D).

16           “(C) EMPLOYEE’S SHARE.—The term ‘em-  
17 ployee’s share’ means, with respect to the appli-  
18 cable premium for any employee, the amount of  
19 the cost to the plan which is paid by the simi-  
20 larly situated beneficiaries who are taken into  
21 account in determining such premium for such  
22 employee.

23           “(D) AUTHORITY TO USE AGE, SEX, AND  
24 GEOGRAPHY IN DETERMINING CONTRIBU-  
25 TION.—

1           “(i) IN GENERAL.—An employer may  
2           elect to determine the applicable premium  
3           for an employee on an actuarial basis tak-  
4           ing into account age, sex, and geography of  
5           the employee and similarly situated bene-  
6           ficiaries.

7           “(ii) DETERMINATION OF EMPLOY-  
8           EE’S SHARE.—In the case of an employer  
9           who determines the applicable premium  
10          under clause (i), the employee’s share of  
11          such premium shall be the same percent-  
12          age of such premium as the employee’s  
13          share of the applicable premium deter-  
14          mined without regard to clause (i).

15          “(iii) CONSISTENCY REQUIRED.—

16               “(I) IN GENERAL.—Except as  
17               provided in subclause (III), an em-  
18               ployer may determine the applicable  
19               premium under this subparagraph for  
20               any employee only if such employer,  
21               and all other employers which are  
22               members of any controlled group  
23               which includes such employer, elect to  
24               determine the applicable premium

1 under this subparagraph for all their  
2 employees.

3 “(II) CONTROLLED GROUP.—All  
4 persons treated as a single employer  
5 under subsection (a) or (b) of section  
6 52 or subsection (m) or (o) of section  
7 414 shall be treated as members of a  
8 controlled group for purposes of sub-  
9 clause (I).

10 “(III) TREATMENT OF SEPARATE  
11 LINES OF BUSINESS.—If an employer  
12 is treated under section 414(r) as op-  
13 erating separate lines of business dur-  
14 ing any taxable year, subclause (I)  
15 shall not apply to employees employed  
16 in such separate lines of business.

17 “(f) SPECIAL RULE FOR MEDICAL SAVINGS AC-  
18 COUNT CONTRIBUTIONS.—Section 220(b)(5) shall not  
19 apply to an employer contribution which is excludable  
20 from gross income under subsection (a).

21 “(g) EXCLUSION APPLICABLE IN DETERMINING EM-  
22 PLOYMENT TAX LIABILITY.—The exclusion under this  
23 section shall be treated for purposes of subtitle C in the  
24 same manner as the exclusion under section 106.”

1 (b) EMPLOYER HEALTH PLAN CONTRIBUTION TO  
 2 BE REPORTED ON W-2.—Subsection (a) of section 6051  
 3 of such Code (relating to receipts to employees) is amend-  
 4 ed by striking “and” at the end of paragraph (10), by  
 5 striking the period at the end of paragraph (11) and in-  
 6 serting a comma, and by inserting after paragraph (11)  
 7 the following new paragraphs:

8 “(12) the amount of the employer health plan  
 9 contribution (as defined in section 139(c)(3)), and

10 “(13) the amount of compensating coverage  
 11 payment (as defined in section 139(c)(1)).”

12 (c) CLERICAL AMENDMENT.—The table of sections  
 13 for such part III is amended by inserting after the item  
 14 relating to section 139 the following new item:

“Sec. 139A. Treatment of compensating payments made for em-  
 ployees who elect not to participate in employer-  
 subsidized health plans.”.

15 (d) EFFECTIVE DATE.—The amendments made by  
 16 this section shall apply to taxable years beginning after  
 17 December 31, 2003.

18 **SEC. 503. EXPANDED AVAILABILITY OF MEDICAL SAVINGS**  
 19 **ACCOUNTS.**

20 (a) REPEAL OF LIMITATIONS ON NUMBER OF MED-  
 21 ICAL SAVINGS ACCOUNTS.—

22 (1) IN GENERAL.—Subsections (i) and (j) of  
 23 section 220 of the Internal Revenue Code of 1986  
 24 are hereby repealed.



1 (2) CONFORMING AMENDMENTS.—

2 (A) Paragraph (1) of section 220(c) of  
3 such Code is amended by striking subparagraph  
4 (D).

5 (B) Section 138 of such Code is amended  
6 by striking subsection (f).

7 (b) ALL EMPLOYERS MAY OFFER MEDICAL SAVINGS  
8 ACCOUNTS.—

9 (1) IN GENERAL.—Subclause (I) of section  
10 220(c)(1)(A)(iii) of such Code (defining eligible indi-  
11 vidual) is amended by striking “and such employer  
12 is a small employer”.

13 (2) CONFORMING AMENDMENTS.—

14 (A) Paragraph (1) of section 220(c) of  
15 such Code is amended by striking subparagraph  
16 (C).

17 (B) Subsection (c) of section 220 of such  
18 Code is amended by striking paragraph (4) and  
19 by redesignating paragraph (5) as paragraph  
20 (4).

21 (c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED  
22 FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

23 (1) IN GENERAL.—Paragraph (2) of section  
24 220(b) of such Code is amended to read as follows:

1           “(2) MONTHLY LIMITATION.—The monthly lim-  
 2           itation for any month is the amount equal to  $\frac{1}{12}$  of  
 3           the annual deductible (as of the first day of such  
 4           month) of the individual’s coverage under the high  
 5           deductible health plan.”.

6           (2) CONFORMING AMENDMENT.—Clause (ii) of  
 7           section 220(d)(1)(A) of such Code is amended by  
 8           striking “75 percent of”.

9           (d) BOTH EMPLOYERS AND EMPLOYEES MAY CON-  
 10          TRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph  
 11          (5) of section 220(b) of such Code is amended to read  
 12          as follows:

13               “(5) COORDINATION WITH EXCLUSION FOR EM-  
 14          PLOYER CONTRIBUTIONS.—The limitation which  
 15          would (but for this paragraph) apply under this sub-  
 16          section to the taxpayer for any taxable year shall be  
 17          reduced (but not below zero) by the amount which  
 18          would (but for section 106(b)) be includible in the  
 19          taxpayer’s gross income for such taxable year.”.

20          (e) EXPANSION OF PERMITTED DEDUCTIBLES.—

21               (1) IN GENERAL.—Subparagraph (A) of section  
 22          220(c)(2) of such Code (defining high deductible  
 23          health plan) is amended—

24                       (A) in clause (i), by striking “not less than  
 25                       \$1,500 and not more than \$2,250” and insert-

1 ing “not less than \$1,000 and not more than  
2 \$5,000”, and

3 (B) in clause (ii), by striking “not less  
4 than \$3,000 and not more than \$4,500” and  
5 inserting “not less than \$2,000 and not more  
6 than \$10,000”.

7 (2) CONFORMING AMENDMENT.—Subsection (g)  
8 of section 220 of such Code is amended—

9 (A) by striking “1998” and inserting  
10 “2003”; and

11 (B) by striking “1997” and inserting  
12 “2002”.

13 (f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED  
14 UNDER CAFETERIA PLANS.—Subsection (f) of section  
15 125 of such Code is amended by striking “106(b),”.

16 (g) EFFECTIVE DATE.—The amendments made by  
17 this section shall apply to taxable years ending after the  
18 date of the enactment of this Act.

1     **TITLE VI—PATIENT ACCESS TO**  
2                     **INFORMATION**

3     **SEC. 601. PATIENT ACCESS TO INFORMATION REGARDING**  
4                     **PLAN COVERAGE, MANAGED CARE PROCE-**  
5                     **DURES, HEALTH CARE PROVIDERS, AND**  
6                     **QUALITY OF MEDICAL CARE.**

7         (a) IN GENERAL.—Subpart 2 of part A of title  
8 XXVII of the Public Health Service Act is amended by  
9 adding at the end the following new section:

10    **“SEC. 2707. PATIENT ACCESS TO INFORMATION REGARD-**  
11                     **ING PLAN COVERAGE, MANAGED CARE PRO-**  
12                     **CEDURES, HEALTH CARE PROVIDERS, AND**  
13                     **QUALITY OF MEDICAL CARE.**

14         “(a) DISCLOSURE REQUIREMENT.—Each health in-  
15 surance issuer offering health insurance coverage in con-  
16 nection with a group health plan shall provide the adminis-  
17 trator of such plan on a timely basis with the information  
18 necessary to enable the administrator to include in the  
19 summary plan description of the plan required under sec-  
20 tion 102 of the Employee Retirement Income Security Act  
21 of 1974 (or each summary plan description in any case  
22 in which different summary plan descriptions are appro-  
23 priate under part 1 of subtitle B of title I of such Act  
24 for different options of coverage) the information required  
25 under subsections (b), (c), (d), and (e)(2)(A). To the ex-

1 tent that any such issuer provides such information on a  
 2 timely basis to plan participants and beneficiaries, the re-  
 3 quirements of this subsection shall be deemed satisfied in  
 4 the case of such plan with respect to such information.

5 “(b) PLAN BENEFITS.—The information required  
 6 under subsection (a) includes the following:

7 “(1) COVERED ITEMS AND SERVICES.—

8 “(A) CATEGORIZATION OF INCLUDED BEN-  
 9 EFITS.—A description of covered benefits, cat-  
 10 egorized by—

11 “(i) types of items and services (in-  
 12 cluding any special disease management  
 13 program); and

14 “(ii) types of health care professionals  
 15 providing such items and services.

16 “(B) EMERGENCY MEDICAL CARE.—A de-  
 17 scription of the extent to which the coverage in-  
 18 cludes emergency medical care (including the  
 19 extent to which the coverage provides for access  
 20 to urgent care centers), and any definitions pro-  
 21 vided under in connection with such coverage  
 22 for the relevant coverage terminology referring  
 23 to such care.

1           “(C) PREVENTATIVE SERVICES.—A de-  
2           scription of the extent to which the coverage in-  
3           cludes benefits for preventative services.

4           “(D) DRUG FORMULARIES.—A description  
5           of the extent to which covered benefits are de-  
6           termined by the use or application of a drug  
7           formulary and a summary of the process for de-  
8           termining what is included in such formulary.

9           “(E) COBRA CONTINUATION COV-  
10          ERAGE.—A description of the benefits available  
11          under the coverage provided pursuant to part 6  
12          of subtitle B of title I of the Employee Retire-  
13          ment Income Security Act of 1974.

14          “(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-  
15          TIONS ON COVERED BENEFITS.—

16               “(A) CATEGORIZATION OF EXCLUDED  
17               BENEFITS.—A description of benefits specifi-  
18               cally excluded from coverage, categorized by  
19               types of items and services.

20               “(B) UTILIZATION REVIEW AND  
21               PREAUTHORIZATION REQUIREMENTS.—Whether  
22               coverage for medical care is limited or excluded  
23               on the basis of utilization review or  
24               preauthorization requirements.

1           “(C) LIFETIME, ANNUAL, OR OTHER PE-  
2           RIOD LIMITATIONS.—A description of the cir-  
3           cumstances under which, and the extent to  
4           which, coverage is subject to lifetime, annual, or  
5           other period limitations, categorized by types of  
6           benefits.

7           “(D) CUSTODIAL CARE.—A description of  
8           the circumstances under which, and the extent  
9           to which, the coverage of benefits for custodial  
10          care is limited or excluded, and a statement of  
11          the definition used in connection with such cov-  
12          erage for custodial care.

13          “(E) EXPERIMENTAL TREATMENTS.—  
14          Whether coverage for any medical care is lim-  
15          ited or excluded because it constitutes experi-  
16          mental treatment or technology, and any defini-  
17          tions provided in connection with such coverage  
18          for the relevant plan terminology referring to  
19          such limited or excluded care.

20          “(F) MEDICAL APPROPRIATENESS OR NE-  
21          CESSITY.—Whether coverage for medical care  
22          may be limited or excluded by reason of a fail-  
23          ure to meet the plan’s requirements for medical  
24          appropriateness or necessity, and any defini-  
25          tions provided in connection with such coverage

1 for the relevant coverage terminology referring  
2 to such limited or excluded care.

3 “(G) SECOND OR SUBSEQUENT OPIN-  
4 IONS.—A description of the circumstances  
5 under which, and the extent to which, coverage  
6 for second or subsequent opinions is limited or  
7 excluded.

8 “(H) SPECIALTY CARE.—A description of  
9 the circumstances under which, and the extent  
10 to which, coverage of benefits for specialty care  
11 is conditioned on referral from a primary care  
12 provider.

13 “(I) CONTINUITY OF CARE.—A description  
14 of the circumstances under which, and the ex-  
15 tent to which, coverage of items and services  
16 provided by any health care professional is lim-  
17 ited or excluded by reason of the departure by  
18 the professional from any defined set of pro-  
19 viders.

20 “(J) RESTRICTIONS ON COVERAGE OF  
21 EMERGENCY SERVICES.—A description of the  
22 circumstances under which, and the extent to  
23 which, the coverage, in including emergency  
24 medical care furnished to a participant or bene-  
25 ficiary of the plan imposes any financial respon-



1           sibility described in subsection (c) on partici-  
2           pants or beneficiaries or limits or conditions  
3           benefits for such care subject to any other term  
4           or condition of such coverage.

5           “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-  
6 ITIES.—The information required under subsection (a) in-  
7 cludes an explanation of—

8           “(1) a participant’s financial responsibility for  
9           payment of premiums, coinsurance, copayments,  
10          deductibles, and any other charges; and

11          “(2) the circumstances under which, and the  
12          extent to which, the participant’s financial responsi-  
13          bility described in paragraph (1) may vary, including  
14          any distinctions based on whether a health care pro-  
15          vider from whom covered benefits are obtained is in-  
16          cluded in a defined set of providers.

17          “(d) ACCOUNTABILITY.—The information required  
18          under subsection (a) includes a description of the legal re-  
19          course options available for participants and beneficiaries  
20          under the plan including—

21          “(1) the preemption that applies under section  
22          514 of the Employee Retirement Income Security  
23          Act of 1974 (29 U.S.C. 1144) to certain actions  
24          arising out of the provision of health benefits;

1           “(2) the ability of a participant or beneficiary  
2           (or the estate of the participant or beneficiary)  
3           under State law to recover damages resulting from  
4           personal injury or for wrongful death against any  
5           person in connection with the provision of insurance,  
6           administrative services, or medical services by such  
7           person to or for a group health plan; and

8           “(3) the extent to which coverage decisions  
9           made by the plan are subject to internal review or  
10          any external review and the proper time frames  
11          under which such reviews may be requested and con-  
12          ducted.

13          “(e) INFORMATION AVAILABLE ON REQUEST.—

14                 “(1) ACCESS TO PLAN BENEFIT INFORMATION  
15                 IN ELECTRONIC FORM.—

16                         “(A) IN GENERAL.—A group health plan  
17                         (and a health insurance issuer offering health  
18                         insurance coverage in connection with a group  
19                         health plan) shall, upon written request (made  
20                         not more frequently than annually), make avail-  
21                         able to participants and beneficiaries, in a gen-  
22                         erally recognized electronic format, the fol-  
23                         lowing information:

1 “(i) the latest summary plan descrip-  
2 tion, including the latest summary of ma-  
3 terial modifications; and

4 “(ii) the actual plan provisions setting  
5 forth the benefits available under the plan,  
6 to the extent such information relates to the  
7 coverage options under the plan available to the  
8 participant or beneficiary. A reasonable charge  
9 may be made to cover the cost of providing  
10 such information in such generally recognized  
11 electronic format. The Secretary may by regula-  
12 tion prescribe a maximum amount which will  
13 constitute a reasonable charge under the pre-  
14 ceding sentence.

15 “(B) ALTERNATIVE ACCESS.—The require-  
16 ments of this paragraph may be met by making  
17 such information generally available (rather  
18 than upon request) on the Internet or on a pro-  
19 prietary computer network in a format which is  
20 readily accessible to participants and bene-  
21 ficiaries.

22 “(2) ADDITIONAL INFORMATION TO BE PRO-  
23 VIDED ON REQUEST.—

24 “(A) INCLUSION IN SUMMARY PLAN DE-  
25SCRIPTION OF SUMMARY OF ADDITIONAL IN-

1           FORMATION.—The information required under  
2           subsection (a) includes a summary description  
3           of the types of information required by this  
4           subsection to be made available to participants  
5           and beneficiaries on request.

6           “(B)   INFORMATION   REQUIRED   FROM  
7           PLANS AND ISSUERS ON REQUEST.—In addition  
8           to information required to be included in sum-  
9           mary plan descriptions under this subsection, a  
10          group health plan (and a health insurance  
11          issuer offering health insurance coverage in  
12          connection with a group health plan) shall pro-  
13          vide the following information to a participant  
14          or beneficiary on request:

15               “(i) NETWORK CHARACTERISTICS.—If  
16               the plan (or issuer) utilizes a defined set of  
17               providers under contract with the plan (or  
18               issuer), a detailed list of the names of such  
19               providers and their geographic location, set  
20               forth separately with respect to primary  
21               care providers and with respect to special-  
22               ists.

23               “(ii) CARE MANAGEMENT INFORMA-  
24               TION.—A description of the circumstances  
25               under which, and the extent to which, the

1 plan has special disease management pro-  
2 grams or programs for persons with dis-  
3 abilities, indicating whether these pro-  
4 grams are voluntary or mandatory and  
5 whether a significant benefit differential  
6 results from participation in such pro-  
7 grams.

8 “(iii) INCLUSION OF DRUGS AND  
9 BIOLOGICALS IN FORMULARIES.—A state-  
10 ment of whether a specific drug or biologi-  
11 cal is included in a formulary used to de-  
12 termine benefits under the plan and a de-  
13 scription of the procedures for considering  
14 requests for any patient-specific waivers.

15 “(iv) PROCEDURES FOR DETERMINING  
16 EXCLUSIONS BASED ON MEDICAL NECES-  
17 SITY OR EXPERIMENTAL TREATMENTS.—  
18 Upon receipt by the participant or bene-  
19 ficiary of any notification of an adverse  
20 coverage decision based on a determination  
21 relating to medical necessity or an experi-  
22 mental treatment or technology, a descrip-  
23 tion of the procedures and medically-based  
24 criteria used in such decision.

1           “(v) PREAUTHORIZATION AND UTILI-  
2           ZATION REVIEW PROCEDURES.—Upon re-  
3           ceipt by the participant or beneficiary of  
4           any notification of an adverse coverage de-  
5           cision, a description of the basis on which  
6           any preauthorization requirement or any  
7           utilization review requirement has resulted  
8           in such decision.

9           “(vi) ACCREDITATION STATUS OF  
10          HEALTH INSURANCE ISSUERS AND SERV-  
11          ICE PROVIDERS.—A description of the ac-  
12          creditation and licensing status (if any) of  
13          each health insurance issuer offering  
14          health insurance coverage in connection  
15          with the plan and of any utilization review  
16          organization utilized by the issuer or the  
17          plan, together with the name and address  
18          of the accrediting or licensing authority.

19          “(vii) MEASURES OF ENROLLEE SAT-  
20          ISFACTION.—The latest information (if  
21          any) maintained by the plan, or by any  
22          health insurance issuer offering health in-  
23          surance coverage in connection with the  
24          plan, relating to enrollee satisfaction.

1                   “(viii) QUALITY PERFORMANCE MEAS-  
2                   URES.—The latest information (if any)  
3                   maintained by the plan, or by any health  
4                   insurance issuer offering health insurance  
5                   coverage in connection with the plan, relat-  
6                   ing to quality of performance of the deliv-  
7                   ery of medical care with respect to cov-  
8                   erage options offered under the plan and  
9                   of health care professionals and facilities  
10                  providing medical care under the plan.

11                  “(C) INFORMATION REQUIRED FROM  
12                  HEALTH CARE PROFESSIONALS ON REQUEST.—  
13                  Any health care professional treating a partici-  
14                  pant or beneficiary under a group health plan  
15                  shall provide to the participant or beneficiary,  
16                  on request, a description of his or her profes-  
17                  sional qualifications (including board certifi-  
18                  cation status, licensing status, and accreditation  
19                  status, if any), privileges, and experience and a  
20                  general description by category (including sal-  
21                  ary, fee-for-service, capitation, and such other  
22                  categories as may be specified in regulations of  
23                  the Secretary) of the applicable method by  
24                  which such professional is compensated in con-  
25                  nection with the provision of such medical care.

1                   “(D) INFORMATION REQUIRED FROM  
2 HEALTH CARE FACILITIES ON REQUEST.—Any  
3 health care facility from which a participant or  
4 beneficiary has sought treatment under a group  
5 health plan shall provide to the participant or  
6 beneficiary, on request, a description of the fa-  
7 cility’s corporate form or other organizational  
8 form and all forms of licensing and accredita-  
9 tion status (if any) assigned to the facility by  
10 standard-setting organizations.

11           “(f) ACCESS TO INFORMATION RELEVANT TO THE  
12 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT  
13 OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition  
14 to information otherwise required to be made available  
15 under this section, a group health plan (and a health in-  
16 surance issuer offering health insurance coverage in con-  
17 nection with a group health plan) shall, upon written re-  
18 quest (made not more frequently than annually), make  
19 available to a participant (and an employee who, under  
20 the terms of the plan, is eligible for coverage but not en-  
21 rolled) in connection with a period of enrollment the sum-  
22 mary plan description for any coverage option under the  
23 plan under which the participant is eligible to enroll and  
24 any information described in clauses (i), (ii), (iii), (vi),  
25 (vii), and (viii) of subsection (e)(2)(B).



1       “(g) ADVANCE NOTICE OF CHANGES IN DRUG  
2 FORMULARIES.—Not later than 30 days before the effec-  
3 tive date of any exclusion of a specific drug or biological  
4 from any drug formulary under the plan that is used in  
5 the treatment of a chronic illness or disease, the plan shall  
6 take such actions as are necessary to reasonably ensure  
7 that plan participants are informed of such exclusion. The  
8 requirements of this subsection may be satisfied—

9               “(1) by inclusion of information in publications  
10       broadly distributed by plan sponsors, employers, or  
11       employee organizations;

12              “(2) by electronic means of communication (in-  
13       cluding the Internet or proprietary computer net-  
14       works in a format which is readily accessible to par-  
15       ticipants);

16              “(3) by timely informing participants who,  
17       under an ongoing program maintained under the  
18       plan, have submitted their names for such notifica-  
19       tion; or

20              “(4) by any other reasonable means of timely  
21       informing plan participants.”.

22 **SEC. 602. EFFECTIVE DATE.**

23       (a) IN GENERAL.—The amendments made by section  
24 601 shall apply with respect to plan years beginning on  
25 or after January 1 of the second calendar year following

1 the date of the enactment of this Act. The Secretary shall  
2 first issue all regulations necessary to carry out the  
3 amendments made by section 601 before such date.

4 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
5 enforcement action shall be taken, pursuant to the amend-  
6 ments made by section 601, against a group health plan  
7 or health insurance issuer with respect to a violation of  
8 a requirement imposed by such amendments before the  
9 date of issuance of final regulations issued in connection  
10 with such requirement, if the plan or issuer has sought  
11 to comply in good faith with such requirement.

